IDRX 3 -

Karasic *Misanin* Deposition Transcript

(Public document)

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF SOUTH CAROLINA

CHARLESTON DIVISION

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STERLING MISANIN, et al.,	)	
	)	
Plaintiffs,	)	
	)	
vs.	)	Case No.
	)	2:24-cv-4734-
ALAN WILSON, in his official capacity as the Attorney General of South Carolina, et al.,	)	BHH
	)	
Defendants.	)	

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FRIDAY, OCTOBER 25, 2024

VIDEOTAPED DEPOSITION OF DAN H. KARASIC, M.D.

CONFIDENTIAL TRANSCRIPT

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REPORTER: BALINDA DUNLAP, CSR 10710, RPR, CRR, RMR

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Frank Quirarte, Videographer

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SAN FRANCISCO, CALIFORNIA, OCTOBER 25, 2024
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BE IT REMEMBERED that on Friday, the 25th day of October 2024, commencing at the hour of 9:03 a.m. thereof, at 39 Drumm Street, Suite 300, San Francisco, California, before me, Balinda Dunlap, a Certified Shorthand Reporter in and for the County of San Francisco, State of California, appeared:

(Reporter marked Exhibit Number 1 for identification.)

THE VIDEOGRAPHER: All right. Good morning, ladies and gentlemen. This is the start of media labeled Number 1 in the video-recorded deposition of Dr. Dan Karasic. It's in the matter 09:02:58
of Sterling Misanin, et al., versus Alan Wilson, et al. It's being held in the United States District Court for the District of South Carolina, Charleston Division. It's Case No. 2:24-cv-4734.

This deposition is being held today at 09:03:20
39 Drumm Street, San Francisco, California. The time is approximately 9:03 a.m.

My name is Frank Quirarte. I am your legal videographer today from Magna Legal Services. Our court reporter is Balinda Dunlap, also in 09:03:39

association with Magna Legal Services.
At this time will counsel and all present please identify yourself for the record.
MR. HILDABRAND: This is Clark Hildabrand with the law firm of Cooper & Kirk representing defendants. 09:03:52
MR. SELDIN: This is Harper Seldin with the ACLU on behalf of plaintiffs.
MS. CAROLAN: This is Aine Carolan of Selendy Gay, PLLC, also on behalf of the plaintiffs. 09:04:06
THE VIDEOGRAPHER: Madam Court Reporter, would you please swear in the witness.
DAN H. KARASIC, M.D.
called as a witness by the Defense, having been sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:
EXAMINATION BY MR. HILDABRAND
Q. All right. Dr. Karasic, we've met online before, but good to meet you in person. Can you just again state your name for the record. 09:04:23
A. Sure. It's Dan Karasic.
Q. Are you competent to give truthful testimony today? 09:04:39

A. Yes.
Q. Are you under the influence of any medications or substances that might make you not competent to give truthful testimony today?
A. No. 09:04:48
Q. I want to go over a few ground rules for our deposition today. I know you've done this before. But please answer all questions verbally so the court reporter can record your verbal response. 09:04:59
Please try not to talk too fast. Try to speak clearly. I'll try to do the same to make sure the court reporter can get everything down.
Please ask me for an explanation if you do not understand my question. If you do not ask for an explanation, I'll assume that you understood my question and that you are answering the question that I asked. 09:05:09
Please try not to interrupt any question I ask. Wait until I'm finished asking, and I'll try to do the same when you're answering questions. Sometimes there's just occasions where it's not clear where the answer to a question stops, so we'll try to get through that. 09:05:19
Counsel for plaintiffs may object to a 09:05:28

question that I ask. But unless they instruct you not to answer the question, you should answer it.
And please let me know if at any time you want to take a break, and we'll take a short lunch break at some point as well. All right. 09:05:40
MR. SELDIN: One -- thank you. One other matter of housekeeping. Plaintiffs maintain at this stage of discovery that this deposition of seven hours is one deposition for the purposes of the entire litigation. So any time that defendants take today deposing Dr. Karasic will come out of a total of seven hours. 09:05:53
I know defendants have taken a different view. That is fine. We'll resolve that at a later date. I just wanted to note for the record. 09:06:05
MR. HILDABRAND: And defendants take the opposite position. But we, of course, just saying that for the record. We'll resolve that at some point.
Q. Dr. Karasic, have you ever given testimony under oath? 09:06:12
A. Yes.
Q. How many times?
A. More than ten, I think.
Q. What's the most recent case? 09:06:22

A. The most recent case was in Voe, the North Carolina case.
Q. And that was last month, right?
A. Yes.
Q. Have you spoken with anyone for the purposes of preparing for this deposition? 09:06:38
A. I spoke with the lawyers present.
Q. Did you tell anyone you were going to be deposed today?
A. My spouse. 09:06:52
Q. Did you review any documents to prepare for this deposition?
A. Yes. I -- I reviewed my declaration and took a quick look at a couple other articles. Mostly reviewed the declaration. 09:07:14
Q. First I'll introduce officially Exhibit 1, which we've marked. Do you mind taking a look at what we've marked as Exhibit 1.
Is that the declaration that you submitted in this case? 09:07:29
A. Yes.
Q. So you mentioned a couple of articles. What articles were those that you looked at to prepare for this deposition?
A. Let's see. I was trying to just think 09:07:36

what I -- what I looked at. So I had -- there was one that was a new article for me that I had just seen from Christine Olson's group, and that was on -- that a high percentage of folks in their study who had started on gender-affirming 09:08:26
medications and remained on those medicines.
Q. That's not an article cited in your declaration, I assume?
A. No. It just -- was just published.
Q. Anything else that you -- articles that 09:08:37
you can remember that you looked at for purposes of this deposition?
A. I'm trying to think specifically for this declaration. I don't recall.
Q. What documents did you review in preparing 09:08:51
your declaration in this case?
A. I reviewed, first of all, prior declarations, and then I reviewed references where I was making sure they were the correct one, like among the Dutch studies -- 09:09:29
(Clarification by the reporter.)
THE WITNESS: I'm sorry. The Dutch studies. They're all Vandermaesen, Vanderloos. They're -- they're all Vander-something, and so checking on it wasn't -- 09:09:37

Q. BY MR. HILDABRAND: See you started -- I'm sorry.
So were you starting from a previous declaration, and you checked your references --
A. Yes. 09:09:48
Q. -- to make sure they were correct?
A. Yes.
Q. Did you review any legislative documents to prepare your declaration?
A. Yes. I reviewed the South Carolina law 09:09:56
and -- and I believe the complaint.
MR. HILDABRAND: I will mark this as Exhibit 2.
(Reporter marked Exhibit Number 2 for identification.) 09:10:30
Q. BY MR. HILDABRAND: If you want to scroll, look through this.
And this is the South Carolina law that you reviewed?
A. Yes. 09:10:36
Q. And what in the complaint did you review?
A. I -- I reviewed a document, a complaint document, that was filed by the counsel for ACLU for the -- for the plaintiffs in this case.
Q. Did -- did you list the complaint in your 09:11:30

declaration as something that you reviewed?
A. I don't know.
Q. So can you point me to somewhere in your declaration where you identified the complaint as something that you reviewed to prepare the 09:11:46
declaration?
A. It may have been at the time of my declaration that I just had reviewed the North Carolina house bill.
Q. Sorry. Do you mean the North Carolina 09:12:04
house bill or the South Carolina house bill?
A. Sorry. The South Carolina house bill. Sorry.
Q. Yeah. You're also a witness in the Voe v. Mansfield, which is the North Carolina case, 09:12:13
correct?
A. Yes.
(Clarification by the reporter.)
Q. BY MR. HILDABRAND: Am I correct that you did not review any statements by particular South 09:12:30
Carolina legislators regarding House Bill 4624?
MR. SELDIN: Object to form.
THE WITNESS: I do not recall reviewing any of those.
Q. BY MR. HILDABRAND: Am I correct that you 09:12:42

did not offer an opinion regarding any animus by the South Carolina Legislature?
MR. SELDIN: Object to form.
THE WITNESS: I did not offer an opinion on that, correct. 09:12:53
Q. BY MR. HILDABRAND: Are you currently preparing a reply declaration for this case?
A. Not yet, but I assume so, the way these things go.
Q. That's why I'm asking. 09:13:05
Have you reviewed the medical records of any plaintiff or class member in this case?
A. No.
Q. Have you interviewed any plaintiff or putative class member in this case? 09:13:19
A. No.
Q. Have you interviewed the parent of any minor plaintiff or putative class member in this case?
A. No. 09:13:27
Q. Am I correct that you do not provide an opinion on the particular medical needs of specific individuals in this case?
MR. SELDIN: Object to form.
THE WITNESS: That's correct. 09:13:34

Q. BY MR. HILDABRAND: Did you previously work at Dimensions Clinic?
A. Yes.
Q. And that's located here in San Francisco; is that right? 09:13:41
A. Yes.
Q. And your patients at Dimensions Clinic were 12 to 25 years old; is that right?
A. Yes.
Q. And you now have a telehealth practice; is that correct? 09:13:49
A. Yes.
Q. And all of your telehealth patients are located in California; is that right?
A. Yes. 09:13:58
Q. None of your telehealth patients live in South Carolina; is that correct?
A. That's correct.
Q. And you've never practiced medicine in South Carolina, correct? 09:14:08
A. That's correct.
Q. You do not personally determine when your patients have begun to enter stage 2; is that correct?
A. That's correct. 09:14:19

Q. And all of your patients are at least at Tanner stage 2; is that correct?
A. That's correct.
Q. Have you performed over 130 medical reviews for the State of California? 09:14:31
A. Yes.
Q. When was the last medical review you performed for the State of California?
A. In the last month.
Q. About how many medical reviews have you performed for the State of California in the last year? 09:14:45
A. You know, it's a good question. So the -- the site where you would enter the reviews used to keep a running count. And then maybe three years ago they changed systems, and the count was 110 then. 09:15:01
And so it's possible I've done 160, 170. I don't know. But just to be conservative, I think I may have said 130. These days I probably do one a month. At one time it was -- it was much more common. 09:15:16
Q. Are you paid for conducting these medical reviews?
A. Yes. 09:15:41

Q. About how much are you paid per medical review?
A. $250 for a routine review. If it's, like, an emergency review, it's 300.
Q. And the last medical review you mentioned, did that review involve gender-affirming care? 09:15:55
A. Yes.
Q. Do most of the reviews that you conducted involve gender-affirming care?
A. All of them do. 09:16:10
Q. And are these medical reviews based on the documents without meeting the patients themselves; is that right?
A. Yes.
MR. SELDIN: Object to form. 09:16:24
THE WITNESS: Yes.
Q. BY MR. HILDABRAND: What is gender-affirming care?
A. So gender-affirming care has more than one meaning depending on how -- the context in which it is applied. When we talk about gender-affirming medical or medical and surgical care, we're talking about care that helps align the body with -- typically with aspects of the person's sense of self for the purpose of treating gender dysphoria. 09:16:40 09:17:05

Q. So you mentioned surgical or medical, but isn't there a broader gender-affirming care not gender-affirming surgical care?
A. Yes. So that includes gender-affirming psychotherapy, which is one that allows the patient or client to -- to explore their understanding of gender as well as any symptoms they may have without a superimposition of the agenda of the -- of the therapist. 09:17:26
Q. Do you agree that psychotherapy is helpful for many gender dysphoric individuals? 09:17:56
MR. SELDIN: Object to form.
THE WITNESS: Yes.
Q. BY MR. HILDABRAND: So you mentioned psychotherapy and then also other treatments, I assume you consider there. 09:18:06
Could you provide a list for me of what are the other treatments that you consider under the gender-affirming care umbrella?
A. So the -- so are you asking other than psychotherapy and medical interventions? Are you asking the types of medical interventions? 09:18:20
Q. Yeah. So what types of medical interventions would you consider part of gender-affirming care? 09:18:41

A. So I would include puberty blockers and hormones used with youth. With adults, hormones, surgical interventions. When done with youth, that's usually chest surgery for transmasculine youth. For adults, that includes genital surgeries. 09:19:16

And then there's -- there are also other surgeries, like breast augmentation for trans women, facial feminization surgery for trans women, other surgeries that help align a person's body with their sense of self. 09:19:40

Q. Breast augmentation, is that a surgery just for trans women? Is that what you said?

A. Yes.

Q. And for adolescents, what specific surgical interventions are included as part of gender-affirming care for adolescents? 09:19:55

MR. SELDIN: Object to form.

THE WITNESS: So in -- at least in common practice, the surgical intervention that is used in adolescents is chest surgery for transmasculine youth. 09:20:13

Q. BY MR. HILDABRAND: So by "chest surgery," what -- what do you mean by "chest surgery"?

A. So it's mastectomy with a reconstruction 09:20:30

of a male-appearing chest typically, although in some, for example, nonbinary people it may just be breast reduction.

Q. Are there any other surgical interventions that are part of gender-affirming care for adolescents? 09:20:52

MR. SELDIN: Object to form.

THE WITNESS: So not -- not typically. Typically genital surgeries aren't done in -- in adolescents. They have been done, but it certainly has not been part of my practice. 09:21:05

Q. BY MR. HILDABRAND: For adults, what sort of genital surgeries do you consider part of gender-affirming care?

A. So that can include vaginoplasty, orchiectomy, phalloplasty, metoidioplasty, which is another surgery for transmasculine people. 09:21:25

I'm sorry. Can you repeat the question?

Q. Yeah. So I just wanted to know what specific surgeries for adults do you consider part of gender-affirming care? 09:21:52

A. So -- so that can include, as I said, facial feminization surgery, breast augmentation, sometimes body-contouring procedures, which is kind of remove all of fat tissue. And then, as I said, 09:22:24

chest surgery for transmasculine adults.

Q. And I think I understand this is correct, but just to make sure.

So are puberty blockers not a gender-affirming care for adults? 09:22:48

A. Correct.

Q. Under the WPATH standards of care -- and WPATH is W-P-A-T-H -- adolescents do not have to receive psychotherapy or mental health counseling before beginning puberty blockers; is that correct? 09:23:05

MR. SELDIN: Object to form.

THE WITNESS: That's -- that's correct. They don't need to be in psychotherapy, but they do need to have a comprehensive mental health evaluation. 09:23:18

Q. BY MR. HILDABRAND: And psychotherapy is distinct from that comprehensive mental health evaluation; is that correct?

A. That's correct.

Q. So in other words, ongoing work with a mental health professional is not required under the WPATH standards of care for prescription of puberty blockers as a treatment for an adolescent's gender dysphoria? 09:23:30

MR. SELDIN: Object to form. 09:23:45

THE WITNESS: So the adolescent chapter recommends an ongoing relationship with a mental practitioner, but it does not require ongoing psychotherapy.

Q. BY MR. HILDABRAND: And since we're talking about puberty blockers for cross-sex hormones, under the WPATH standards of care, adolescents do not have to receive -- 09:23:58

(Clarification by the reporter.)

MR. HILDABRAND: I'll start again and go slower this time. 09:23:58

Q. BY MR. HILDABRAND: Under the WPATH standards of care, adolescents do not have to receive psychotherapy before beginning cross-sex hormones; is that correct? 09:24:17

MR. SELDIN: Object to form.

THE WITNESS: So that's correct. They need to receive an evaluation, but they don't need to be in psychotherapy.

Q. BY MR. HILDABRAND: And then just to be clear, ongoing work with a mental health professional is not required under the WPATH standards of care for a prescription of cross-sex hormones as treatment for an adolescent's gender dysphoria? 09:24:30 09:24:46

MR. SELDIN: Object to form.
THE WITNESS: It's recommended but not required.
Q. BY MR. HILDABRAND: If you will look at your declaration, paragraph 37 here. It's on page 10. I don't know if that's helpful. 09:24:54
Do you see where you say in paragraph 37 that the SOC8 -- and just so we're clear, the SOC8 stands for Standards of Care Version 8 published by WPATH; is that right? 09:25:20
A. That's correct.
Q. So the SOC8 provides guidelines for multidisciplinary care of transgender individuals.
Is that what you said in that part of your declaration? 09:25:30
A. Yes.
Q. But you agree that in the U.S., most transgender care is provided in private practice settings and there's no multidisciplinary team present? 09:25:41
MR. SELDIN: Object to form. Foundation.
MR. HILDABRAND: What's the objection to form for the question?
MR. SELDIN: Could you read the question back, please. 09:25:49

(Record read as follows:
"QUESTION: But you agree that in the U.S., most transgender care is provided in private practice settings and there's no multidisciplinary team present?") 09:25:37
MR. SELDIN: Vague as to defined terms.
But you can answer the question. I'm not going to instruct you not to answer.
Q. BY MR. HILDABRAND: So let me repeat the question again. 09:26:21
Do you agree in the U.S., most transgender care is provided in private practice settings and there's no multidisciplinary team present?
MR. SELDIN: And I will renew. Same objection. 09:26:30
THE WITNESS: Yes. Even though multidisciplinary care, I think, is much more common in transgender care than in other aspects of care, even in the United States, I believe, you know, the great majority of the care in the United States is delivered in a private practice office. 09:26:41
Q. BY MR. HILDABRAND: So do you agree that in the vast majority of cases, transgender care in the United States is delivered without a 09:26:59

multidisciplinary team present?
MR. SELDIN: Object to form.
THE WITNESS: I would say yes, particularly with adults. The most common way that adults receive care is with their primary care provider as they do for other forms of care. 09:27:13
Q. BY MR. HILDABRAND: Were you an expert witness in a case in the state of Washington?
A. Yes.
Q. And was that case C.P. v. Blue Cross Blue Shield of Illinois? 09:27:38
A. Yes.
MR. HILDABRAND: I will give you a copy of this and mark this as, I think, Exhibit 3.
(Reporter marked Exhibit Number 3 for identification.) 09:27:51
Q. BY MR. HILDABRAND: Did you testify at a deposition in C.P. v. Blue Cross Blue Shield of Illinois?
A. Yes. 09:28:11
Q. Did that deposition occur in July of 2022?
A. I -- I believe so, yes. I'd have to look at the date, but that sounds right.
Q. Does this appear --
A. Here it is. 09:28:24

Q. I'm sorry. Does this appear to be your -- the deposition transcript from your deposition in that case?
A. Yes.
Q. If you can, please turn to page 87 in the transcript. 09:28:32
So in the Washington case, is there an individual called C.P. who was involved?
A. Yes.
Q. Was C.P. a minor? 09:28:59
A. Yes.
Q. So you're asked a question here. Do you see on Page 87, lines 3 to 5, did you testify that "but in the U.S., most transgender care is provided in private practice settings and there's no multidisciplinary team present"? 09:29:13
A. Yeah, can you give me the line? But that sounds -- sounds right.
Q. Page 87, lines 3 through 5.
A. Oh, I'm sorry. (Sotto voce.) 09:29:26
Q. It is page 87 of the deposition transcript. You'll have -- at the top of the page it should have page 162 of 598 where it was filed in the docket. But in the deposition transcript, it should have page 87. 09:29:46

A. Oh, I see it. Okay. Page 87, yes.
Q. So just I'll repeat the question, just sort of make sure we're clear.
Did you testify during your deposition in the C.P. case that "but in the U.S., most 09:30:21
transgender care is provided in private practice settings and there is no multidisciplinary team present"?
MR. SELDIN: I'll just object. This is three lines of a much longer answer that contains 09:30:35
additional context on pages 86 and 87.
But you can answer.
THE WITNESS: Yes, I testified to that.
Q. BY MR. HILDABRAND: And counsel for plaintiffs mentioned a larger context, and it's 09:30:47
from line 14 on page 86.
Do you see where the question begins?
A. On -- okay.
Q. It would be on the left-hand side here.
A. Yes. Yes. 09:31:09
Q. And lines 14 to 19, is that how you remember the question that you were asked?
A. Yes.
Q. And then lines 20 on page 86 through line 8 on page 87, is that an accurate reflection 09:31:22

of how you testified during this deposition?
A. Yes. I mean, maybe if someone's referring to a larger context, there's the next sentence that says, "There can be referrals to people from other disciplines. In other words, American healthcare 09:31:41
usually isn't structured in terms of a team working in one setting but, rather, people in private practice who might refer out as necessary."
Q. And if you want to turn in your declaration -- I put the documents together, and 09:32:01
we'll refer to them later on, but you can set them aside for now.
A. Okay.
Q. If you want to turn in your declaration back to paragraph 29. This should be on page 7. 09:32:15
Do you see where you say here that "at birth, infants are assigned a sex, either male or female, based on the appearance of their external genitalia"?
A. Yes. 09:32:34
Q. And am I correct that you did not provide any citation for this claim?
A. No.
Q. You did not -- to be clear, you did not provide any citation for this claim? 09:32:44

A. No.
Q. So just to be clear, the answer is "yes," you did not provide any citation for this claim; is that correct?
MR. SELDIN: Object to form. 09:32:57
But you can answer if you understand.
Q. BY MR. HILDABRAND: Maybe you just want to explain.
A. Yes. That statement does not have a citation. 09:33:06
Q. Thank you.
And you do personally not make sex assignments for infants?
MR. SELDIN: Object to form.
THE WITNESS: That's correct. 09:33:13
Q. BY MR. HILDABRAND: And then going to the next paragraph here, paragraph 30, am I correct that you cite Hembree 2017 as your only authority other than the challenged at for this paragraph about the definition of sex? 09:33:24
A. Yes. I only cited Hembree.
Q. And is Hembree 2017 the 2017 Endocrine Society guidelines?
A. Yes.
MR. HILDABRAND: I will introduce this in 09:33:35

a second here. I will introduce these as Exhibit 4.
(Reporter marked Exhibit Number 4 for identification.)
Q. BY MR. HILDABRAND: Doctor, do you 09:34:08
recognize these as the Endocrine Society guidelines from 2017?
A. Yes.
Q. All right. Can you turn to page -- it's 3875 in this document. 09:34:21
Do you see Table 1, "Definitions of Terms Used in this Guideline"?
A. Yeah, I see Table 1.
Q. Do you see down here where Table 1 defines the word "sex"? 09:34:47
A. Yes.
Q. And the definition of sex as provided by the 2017 Endocrine Society guidelines is "Sex: This refers to tributes that characterize biological maleness or femaleness" -- 09:35:06
(Clarification by the reporter.)
Q. BY MR. HILDABRAND: "Sex: This refers to attributes that characterize biological maleness or femaleness. The best-known attributes include sex-determining genes, the sex chromosomes, the H-Y 09:35:19

antigen, the gonads, sex hormones, internal and external genitalia, and secondary sex characteristics."

Is that the definition that Hembree 2017 provided for the word "sex"? 09:35:43

A. Yes. But that same table does have a definition for "biological sex," which includes that statement that the terms "biological sex" and "biological male or female" are imprecise and should be avoided. 09:36:02

Q. And it does not include that statement in the definition of "sex"; is that correct?

MR. SELDIN: Object to the form.

THE WITNESS: It has a separate -- the same table has a separate listing for the 09:36:11 definition of "biological sex."

Q. BY MR. HILDABRAND: And the Endocrine Society guidelines do not include gender identity as an attribute for sex, correct?

MR. SELDIN: Objection to form. Misstates 09:36:26 the document.

Q. BY MR. HILDABRAND: All right. So he's saying I'm misstating the document. So if you look at the definition of "sex," do you see gender identity included as an attribute for sex in the 09:36:32

definition in Hembree 2017?

A. No.

Q. And Hembree 2017 also does not include variations in brain structure and function as an attribute for sex, correct? 09:36:48

A. Correct.

Q. And you agree that sex is a physical characteristic, right?

MR. SELDIN: Object to form.

THE WITNESS: Sex -- so as -- as one 09:37:06 refers to sex assigned at birth, sex is a physical characteristic. There's also, you know, the sexual act, et cetera.

Q. BY MR. HILDABRAND: Yeah. So not including sexual intercourse. 09:37:26

A. Yes.

Q. When I am referring to the word "sex," sex is a physical characteristic, correct?

A. Sex usually refers to physical characteristics, yes. 09:37:36

Q. And do you agree that sex, not sexual intercourse, is based on an evaluation of external genital appearance in chromosomal sex?

MR. SELDIN: Object to form.

THE WITNESS: So the sex assigned at birth 09:37:50

is connected to genital appearance. There are some people who either have ambiguous genitalia or who -- at least cursory examination of the genitalia identifies them as a sex other than their chromosomes, for example, people with X-Y 09:38:22 chromosomes with complete androgen insensitivity.

(Clarification by the reporter.)

Q. BY MR. HILDABRAND: Did you testify at deposition in a case in Arkansas?

A. Yes. 09:38:41

Q. And was that case Brandt, B-r-a-n-d-t, v. Rutledge, R-u-t-l-e-d-g-e?

A. Yes.

MR. HILDABRAND: All right. I'm going to enter this as Exhibit 5. 09:38:56

(Reporter marked Exhibit Number 5 for identification.)

MR. SELDIN: Do you have a copy of it, Counsel?

MR. HILDABRAND: I'm not sure if I have one here.

Do you mind if counsel uses the one that's marked right now?

(Discussion off the record.)

Q. BY MR. HILDABRAND: Is this a copy of your 09:39:35

deposition transcript in that case?

A. Yes.

Q. And you testified under oath in May 2022 in Brandt v. Rutledge; is that correct?

A. Yes. 09:39:49

Q. Can you turn to -- it's page 66. Were you -- starting at line 21, were you asked the question, "Okay. Is a person's sex a physical characteristic of the person?"

A. Yes. 09:40:24

Q. And was your answer starting at line 23, "So sex -- someone's sex -- generally, that -- when one is using that word, typically one is referring to some specific things like sex assigned at birth, which is physical because it's based on an 09:40:43 evaluation of external genital appearance; chromosomal sex, which, you know, can be determined by examining their chromosomes"?

A. So in that response there's a semicolon because I had a pause. So sex assigned at birth is 09:41:01 based on evaluation of external genitalia -- genital appearance. Chromosomal sex is based on examining their chromosomes. But those two aren't always -- they're usually the same, but they're not always the same. 09:41:18

Q. Is the text of this document an accurate reflection of how you responded during this deposition?
A. Yes. Because the -- the text has a sem -- semicolon, so a pause. In other words, sex assigned at birth is -- is based on evaluation of external genital appearance. Chromosomal sex is determined by examining chromosomes. In other words, there's often a qualifier with sex of -- of the -- how you're determining the sex you're describing. 09:41:31 09:41:53
Q. So you look at external genital appearance, but you might also consider the chromosomes; is that correct?
A. No. So sex assigned at birth, no one is looking at the chromosomes typically. If they assign it at birth, it's in the, you know, delivery room, and so that's based on appearance. But -- so somebody might talk about people's sex assigned at birth. 09:42:06 09:42:28
But in another context, there might be a discussion of chromosomal sex. And chromosomal sex, though it usually aligns with genital appearance, it doesn't always.
So what I was trying to say here is that 09:42:41

when you're talking about sex, that you designate sex assigned at birth versus, for example, chromosomal sex.
Q. So sex is not always the same as sex assigned at birth; is that right? 09:42:58
A. Yes.
Q. And the Endocrine Society guidelines also defined gender identity; is that right?
A. Let me get back to that table. Yes.
Q. And so then let's go back to -- switch documents to your declaration, so back to paragraph 31. It's on page -- the bottom of page 7, going to the top of page 8. 09:43:20
Am I correct that here you did not include the Endocrine Society's definition of gender identity? 09:43:43
A. Wait.
Q. Your declaration marked as Exhibit 1, paragraph 31, which is on page 7 going on to the top of page 8. 09:43:57
A. Sorry.
Q. Sorry.
A. Yes. So that reference was from the American Psychological Association, that -- that quote. 09:44:12

Q. And --
A. But -- but it's similar to -- it looks like, to the one used in the Endocrine Society paper.
Q. But I'm correct that you did not cite the Endocrine Society in paragraph 31; is that right? 09:44:26
A. Correct. I cited the American Psychological Association.
Q. Did you alter the American Psychological Association's definition of gender identity? 09:44:39
A. I -- it was a quote. It looks like I put a bracket for "or another" genders. So but the rest of it is -- is a quote from American Psychological Association 2015, page 862 --
(Clarification by the reporter.) 09:45:05
THE WITNESS: Page 862. That's at least what I referenced.
Q. BY MR. HILDABRAND: Do you remember what the source originally said before you bracketed part of it? 09:45:20
A. No.
MR. HILDABRAND: We'll take a look at it. We'll mark this as Exhibit 6.
(Reporter marked Exhibit Number 6 for identification.) 09:45:53

Q. BY MR. HILDABRAND: So, Dr. Karasic, is this what you cited as the American Psychological Association 2015?
A. Yes, I believe so.
Q. Do you mind turning to page 862. And before you do that, can you go to page 860 just so we can get this context here? 09:46:09
A. Oh, page 860.
Q. Sorry. Do you see on page 860 where it says "Appendix A, Definitions"? 09:46:38
A. Yes.
Q. So this is the definition section of this document?
A. Yes.
Q. Okay. Then let's go over to page 862. 09:46:48
Do you see where the document provides a definition of gender identity at the top here?
A. Yes.
Q. And did the American Psychological Association 2015 define gender identity as a "Person's deeply felt inherent sense of being a boy, a man, or male, a girl, a woman, or female, or an alternative gender (e.g., gender queer, gender nonconforming, gender neutral) that may or may not correspond to a person's sex assigned at birth or 09:47:07 09:47:32

to a person's primary or secondary sex characteristics. Because gender identity is internal, a person's gender identity is not necessarily visible to others. Affirmed gender identity refers to a person's gender identity after coming out as TGNC or undergoing a social and/or medical transition process"? 09:47:49

A. Yes.

Q. Do you agree that gender queer is a gender identity? 09:48:09

A. So gender queer was a gender identity that was commonly used in the 2000s and early 2010s before nonbinary found common usage. And so people were -- I think there was kind of an eventual adoption of nonbinary as an umbrella term for the different ways that people who identified as neither male nor female label themselves. And so gender queer was a common one in a -- in an earlier era but not common now. 09:48:43

Q. But do you agree that gender queer is a gender identity? 09:49:04

A. So yeah. Gender queer is a gender identity that people ascribe to themselves.

Q. And so did some people used to describe themselves gender queer or gender identity but now 09:49:18

they describe themselves as gender nonbinary; is that correct?

A. That's correct.

Q. Do you agree that gender nonconforming -- sorry. Do you agree that gender nonconforming is a gender identity? 09:49:30

A. So gender nonconforming was a descriptor that sometimes people used for nonbinary, but it was also sometimes used to describe people who -- whose gender expression, for example, was -- was nonbinary, or even gender expression was different from cisgender youth. 09:50:02

So it was more commonly used at one point in -- in describing what are now -- now very often called gender diverse people, particularly youth. 09:50:28

Q. Just to make sure I'm understanding, gender nonconforming is a gender identity, though, right?

MR. SELDIN: Object to form.

THE WITNESS: So gender nonconforming is -- can be a gender identity, but it's not as common -- common usage. It's either people describing themselves as their gender is nonbinary or -- it also, though, gender nonconforming was used as a descriptor for people, especially young 09:50:41 09:51:13

people whose behavior was different from their cisgender peers.

Q. BY MR. HILDABRAND: So -- and -- just to get to the other part you were testifying about earlier, so some people used to describe themselves as gender nonconforming but later identify themselves as gender diverse or gender nonbinary? 09:51:27

A. So yes. But I think the more common usage was particularly in prepubertal children where gender nonconforming was not their self-descriptors so much as rather descriptors of parents or clinicians and -- that may -- may use the words "gender diverse" now, but still sometimes use "gender nonconforming," so less often an identity that someone put forward, but some people -- some people did. 09:52:00 09:52:22

Q. And so you mentioned it is often used by doctors or parents.

So would parents or doctors use the term "gender nonconforming" to refer to a prepubertal child if that child wasn't acting how you'd expect a stereotypical boy or stereotypical girl to act? 09:52:32

A. Yes.

Q. And do you agree that gender neutral is a gender identity? 09:52:49

A. So again, it -- it has been used by some people as a gender identity. Again, more often now people would just -- would use the term "nonbinary."

Q. But you'd agree that gender neutral is a gender identity, right? 09:53:14

A. So gender neutral can be a descriptor of someone's gender identity.

Q. Do you agree that people that identify as gender queer may redefine gender or decline to define themselves as gender altogether? 09:53:32

A. That sounds like a quote from somewhere.

Q. Oh, sorry. It's a quote from -- right. Sorry. I am not trying to -- it's a quote from right here, I think, what we just read. 09:53:56

MR. SELDIN: As you can see, I barely need to be here.

Q. BY MR. HILDABRAND: But I'm not trying to trap you with this. But I'm just asking, do you agree with that statement, that people who identify as gender queer may redefine gender or decline to define themselves -- 09:54:03

(Clarification by the reporter.)

Q. BY MR. HILDABRAND: Yeah. So do you agree that people who identify as gender queer may 09:54:12

redefine gender or decline to define themselves as gender altogether?

A. So again, gender queer is not so much in common usage now, but it did -- and I'm not quite sure what redefining gender means. But it could include people who decline to identify themselves as male or female. And in -- in that sense, many of those people would describe themselves as nonbinary now. 09:54:41

Q. And to people who identify as gender queer may think of themselves as both man and woman, bigender, pangender, androgyne -- that's a-n-d-r-o-g-y-n-e -- neither man nor woman, genderless, gender neutral, neutrois, n-e-u-t-r-o-i-s, agender, moving between genders, gender fluid, or embodying a third gender? 09:55:04 09:55:22

A. So that's a list of ways in asking, for example, in psychotherapy, with someone who identifies as nonbinary how they might describe their gender. Those are descriptors that people might -- might give. 09:55:48

As I say, again, it's -- you know, "nonbinary" has -- has kind of largely taken the place of "gender queer." But there are some people who still use that or other -- come up with other 09:56:12

terms that, let's say, in psychotherapy to try to describe their understanding of their gender.

Q. So their understanding of their gender or their understanding of their gender identity?

A. Their -- their understanding of their gender identity. 09:56:33

Q. Do some non -- do some nonbinary people not consider themselves to be transgender?

MR. SELDIN: Object to form.

THE WITNESS: So people -- people can put the labels on themselves that they choose to put on themselves. But typically we do look at nonbinary people within that transgender umbrella, recognizing that there can be differences between the range of identities of nonbinary people from people who have a binary cross-gender identity. 09:56:49 09:57:21

Q. BY MR. HILDABRAND: When you say we do not put, do you mean doctors, psychiatrists, psychologists?

A. Yeah. So that we -- when you said "we do not put," we -- we generally put them in -- the nonbinary people in the category with binary transgender people but recognize that there are differences both in terms of their identity and in terms of -- and often in terms of their -- their 09:57:38 09:58:05

needs.

Q. So you would say -- when you say "we" in your answer, do you mean healthcare providers?

A. Healthcare providers.

MR. SELDIN: And, Mr. Hildabrand, I think we've been going the better part of an hour. I'm not sure where you are in this line. 09:58:18

MR. HILDABRAND: I'm pretty close to the ending of this section here, so maybe five more minutes and we can take a break. 09:58:32

MR. SELDIN: Is that okay?

THE WITNESS: Yeah. That's fine.

Q. BY MR. HILDABRAND: But some binary people themselves do not consider themselves to be transgender; is that right? 09:58:38

MR. SELDIN: Object to form.

THE WITNESS: I -- I can't account for -- for everybody's identity, but people do identify and individualize in individualized ways.

Our focus as clinicians is on people's -- the presence or absence of gender dysphoria. But certainly, when we're working with somebody in psychotherapy, it is important for us to have an understanding of how they identify. 09:59:00

MR. HILDABRAND: I'm going to hand you 09:59:20

what I will mark as, I think, Exhibit 7.

(Reporter marked Exhibit Number 7 for identification.)

Q. BY MR. HILDABRAND: Are these the WPATH Standards of Care Version 8? 09:59:37

A. Yes.

Q. And you were one of the coauthors of these standards of care; is that right?

A. Yes.

Q. Are you the chair of the mental health chapter? 09:59:51

A. Yes.

Q. Let's go to -- it's page S252 in here. I think this is toward the end. But you probably know this better than I do. 10:00:16

MR. SELDIN: I don't know, Mr. Hildabrand. There have been a lot of these cases.

Q. BY MR. HILDABRAND: Do you see at the top of S252 "Appendix B: Glossary"?

A. Yes. 10:00:34

Q. So this is a glossary of different terms used in WPATH's Standards of Care Version 8?

A. Yes.

Q. Do you see -- it's on the right-hand column here -- the term -- the term "nonbinary"? 10:00:47

A. Yes.
Q. Do you see within that definition that "some nonbinary people consider themselves to be transgender or trans; some do not because they consider transgender to be part of the gender binary"? 10:01:07
A. Yes.
Q. And do you agree with that statement?
A. Well, yes. As I said, people have different descriptors of themselves. And so whether or not somebody considers being nonbinary part of a larger being transgender or whether they -- in this case it says some people consider being transgender to be part of a gender binary. 10:01:22
Our conception generally is, as healthcare providers, that a kind of broader description of transgender to include nonbinary people, but there may be people who disagree with that. 10:01:54
Q. Okay. So healthcare providers' understanding of an individual's gender identity is not always the same as how that individual expresses their gender identity? 10:02:16
MR. SELDIN: Object to form. Misstates testimony.
THE WITNESS: Yeah. So as clinicians, 10:02:26

there are some things that are -- are pretty rigidly the same. You know, do people meet diagnostic criteria for gender dysphoria, for example, or do people have clinical symptoms.
But identity, and particularly when you get to nonbinary people's identity, it can be individualistic. 10:02:44
Q. BY MR. HILDABRAND: Okay. Is eunuch also a gender identity?
A. So there are people who identify as eunuchs as their gender identity. 10:03:08
Q. And you've diagnosed individuals who identify as eunuch with gender dysphoria; is that correct?
A. I have, a few. 10:03:19
MR. HILDABRAND: All right. Let's go -- I think we -- if we want to take a break, we can stop there.
Let's go off the record.
THE VIDEOGRAPHER: We are off the record. 10:03:31
The time is 10:03 a.m.
(A recess was taken.)
THE VIDEOGRAPHER: We're back on the record. The time is 10:11 a.m.
Q. BY MR. HILDABRAND: Let's go back to your 10:12:15

declaration real fast.
A. Uh-huh.
Q. Can you go to paragraph 31.
Do you see here on page -- top of page 8, where you say "Gender identity, which has biological bases, is not a product of external influence and not subject to voluntary change"? 10:12:30
A. Yes.
Q. Am I correct that you do not provide any authority for the statement that gender identity has biological bases? 10:12:44
A. I don't -- I did not put a reference, no.
Q. Thank you.
Did you have any discussions with counsel during the break that we just had? 10:12:56
A. No.
Q. Let's go to paragraph 33.
Do you see where you say that "gender dysphoria" -- paragraph 33 is on page 8. Sorry.
All right. Do you see where you say that "Gender dysphoria is distress related to the incongruence between one's gender identity and attributes related to one's sex assigned at birth"? 10:13:13
A. Yes.
Q. Is that correct statement? 10:13:27

A. Yes.
Q. And the DSM-V has diagnoses for gender dysphoria in children --
A. Yes.
Q. -- and gender dysphoria in adolescents and adults; is that correct? 10:13:36
A. Yes.
Q. And those are distinct diagnoses?
A. Yes.
Q. And it looks like you copied the criteria for those two diagnoses here in paragraphs 34 and 35 in your declaration? 10:13:43
A. Yes.
Q. In minors with a diagnosis of gender dysphoria in children are not eligible for puberty blockers, cross-sex hormones, or surgery as a treatment for that gender dysphoria; is that right? 10:13:56
A. Right. Prepubertal children who are the people who receive the gender dysphoria in children diagnosis did not receive medical intervention. 10:14:16
Q. So only individuals with a gender dysphoria in adolescents and adults diagnosis are eligible for --
(Clarification by the reporter.)
Q. BY MR. HILDABRAND: Yeah. So only 10:14:35

individuals with a gender dysphoria in adolescents and adults diagnosis are eligible for pubertal suppression, cross-sex hormones, or surgery as a treatment for gender dysphoria; is that correct?
A. I'm sorry. Can you repeat the question? 10:14:47
Q. So an individual cannot receive pubertal suppression, cross-sex hormones, or surgery as a treatment for gender dysphoria if they do not have a gender dysphoria in adolescents and adults diagnosis; is that right? 10:15:01
A. That's correct.
Q. And so here in paragraph 35, you have the criteria for gender dysphoria in adolescents and adults; is that right?
A. Yes. 10:15:14
Q. And so you have -- there's an "A" requirement here at the top; is that right?
A. Yes.
Q. And to satisfy this "A" requirement, the patient must have two of the following criteria 10:15:22 from 1 through 6 --
A. Yes.
Q. -- is that right?
Sorry. Is the answer "yes"?
A. Yes. Sorry. 10:15:30

Q. And to satisfy the "B" requirement, the patient must have clinically significant distress or impairment in social, occupational, or other important areas of functioning, correct?
A. Yes. 10:15:44
Q. Does the DSM-V also have an other specified gender dysphoria diagnosis?
A. Yes.
Q. And individuals with other specified gender dysphoria do not meet the full criteria for 10:15:55 gender dysphoria?
A. Correct.
Q. And does the DSM-V also have an unspecified gender dysphoria diagnosis?
A. The -- I -- I believe that's covered in 10:16:17 the other -- you just mentioned the other specified diagnosis. I'm not sure about a difference between other specified and unspecified.
Q. So your understanding is that unspecified gender dysphoria is part of other specified gender 10:16:36 dysphoria in the DSM-V?
MR. SELDIN: Object to form.
THE WITNESS: I don't recall if they list it that way.
Q. BY MR. HILDABRAND: And so individuals -- 10:16:47

regardless of how it's listed, individuals with unspecified gender dysphoria also don't meet the full criteria for gender dysphoria; is that right?
A. Right.
MR. SELDIN: Object to form. 10:16:56
THE WITNESS: The DSM, they changed their labels with DSM-V, but they've always had a category for people who don't fully meet the criteria for -- for diagnosis.
Q. BY MR. HILDABRAND: And so when we're 10:17:15 talking about the DSM-V, can you explain what the DSM-V is?
A. Sure. So the diagnostic and statistical manual for mental disorders has -- is periodically updated by the American Psychiatric Association. 10:17:30 The current version is DSM-V-TR. The TR referred to text revision. But the criteria are -- are generally the same as in DSM-V. It's just they update the descriptive text.
Q. Gotcha. So gender dysphoria did not exist 10:17:59 as a diagnosis until 2013 with the publication in the DSM-V, right?
A. That's correct. It replaced gender identity disorder, which was a diagnosis in -- in the previous DSM-IV. 10:18:15

Q. For example, a child might have been diagnosed with gender identity disorder in children in the DSM-IV; is that right?
A. That's correct.
Q. And a child with gender identity disorder 10:18:29 in children was not necessarily transgender; is that right?
(Clarification by the reporter.)
MR. HILDABRAND: Transgender.
THE WITNESS: Right. That there were 10:18:39 people who had gender identity disorder of childhood who had strong cross-gender behaviors but didn't have a transgender identity.
Q. BY MR. HILDABRAND: So we don't know if you've included in research about gender identity 10:19:02 disorder before 2013 met the diagnostic criteria for gender dysphoria; is that right?
MR. SELDIN: Object to form.
THE WITNESS: I'm sorry. I didn't hear the question. 10:19:15
Q. BY MR. HILDABRAND: Yeah. So we don't know if you included in research about gender identity disorder before 2013 met the diagnostic criteria for gender dysphoria?
MR. SELDIN: Same objection. 10:19:28

THE WITNESS: I'm -- I'm still not quite sure what you're asking.
Q. BY MR. HILDABRAND: Yeah. So there was research done on children with gender identity disorder -- 10:19:36
A. Right.
Q. -- before the year 2013, correct?
A. Yes.
Q. And we cannot know if all the youth in those studies met the criteria for gender 10:19:44 dysphoria; is that right?
A. That -- that's correct. There were in those studies people who actually were not given a diagnosis at all who were included in this study just because they were brought into the clinic for 10:20:00 cross-gender behavior.
And then there were those who met gender identity disorder in -- in children diagnosed -- diagnosis. But because the A-1 criteria relating to a transgender identity was not part of the 10:20:22 diagnosis -- not a required part -- it was one criterion, but they could meet that -- the diagnosis only on behavior until DSM-IV -- I mean DSM-V.
Q. Gotcha. And having a gender dysphoria in 10:20:44

children diagnosis does not necessarily mean that a minor is transgender; is that right?
MR. SELDIN: Objection to form.
THE WITNESS: So in -- in the diagnosis now, there is this A-1 criteria. But we -- we give 10:21:05 a clinical diagnosis, which can be different from self-identity. So -- so there are people who label prepubertal children as transgender children, and there are those who prefer to use a broader term, like gender diverse, to -- to include people who -- 10:21:39 who may or may not have a transgender identity.
Q. BY MR. HILDABRAND: Gotcha. Did you testify in a case in West Virginia?
A. Yes.
Q. And to clarify, did you testify at 10:22:03 deposition in that West Virginia case?
A. Yes.
MR. HILDABRAND: I believe this is Exhibit 8 that we're on.
(Reporter marked Exhibit Number 8 10:22:19 for identification.)
Q. BY MR. HILDABRAND: And this -- this redacts material that says "confidential" here, but I'm not going to ask you, of course, about that.
But does this reflect your deposition 10:22:29

transcript from that April 2022 deposition?
A. Yes.
Q. And you were under oath for that deposition; is that correct?
A. Yes. 10:22:40
Q. Can you turn to page 26. If you look at 26, lines 8 through 10.
A. Yes.
Q. Do you see where you -- do you testify that -- that having gender dysphoria in children is 10:23:03 not necessarily the same thing as being a transgender person?
A. Yes.
MR. SELDIN: I'll just note for the record that's a small excerpt of a larger question -- of a 10:23:11 larger answer to a question that goes on to page 25.
Q. BY MR. HILDABRAND: Does the transcript here accurately reflect the question and the full answer that you provided? 10:23:22
MR. SELDIN: And, Dr. Karasic, the question is on page 25.
THE WITNESS: Yes. But I think that that -- that what I said then, gender dysphoria in children is not necessarily the same thing as being 10:23:54

a transgender person, you know, holds with or without the context. Because gender dysphoria is a diagnosis we make, and being a transgender person is not going to be an --
(Clarification by the reporter.) 10:24:20
THE WITNESS: An identity that someone has. And so -- yeah, so I think that answer is correct.
Q. BY MR. HILDABRAND: Okay. Let's go to paragraph 50. We can move away from that document, 10:24:31 set it aside.
Let's go to paragraph 56 in your declaration.
Do you see in the first sentence here on paragraph 56 where you say, "Many bills like the 10:25:00 one passed in South Carolina claim that for most youth, gender dysphoria will resolve on its own, making medical interventions unnecessary"?
A. Yes.
Q. Here you're not talking about anything 10:25:13 specific in South Carolina's law, correct?
A. No.
Q. And you didn't review any other bills or laws in preparing your declaration; is that correct? 10:25:24

A. That's correct.
Q. Other than gender dysphoria in adolescents and -- sorry. Other than gender dysphoria in adolescents and adults, no other psychiatric diagnosis is treated with surgery; is that correct? 10:25:33
MR. SELDIN: Object to form.
THE WITNESS: There are very, very rare cases. There have been people with very severe OCD who've had singular -- cingulate -- cingulate gyrus surgery, a little part of the brain, when all else 10:26:09 has -- has failed.
There are people who get insertions of electrodes essentially for treatment-resistant depression. But surgery is not the typical intervention for diagnoses in the -- in the DSM. 10:26:34
Q. BY MR. HILDABRAND: So can you name any other -- can you name any diagnosis in the DSM other than gender dysphoria in adolescents and adults for which surgery is a recommended treatment? 10:26:53
MR. SELDIN: Object to form.
THE WITNESS: So I said, in rare cases, major depressive disorder severe recurrent that's treatment resistant and, in rare cases, severe obsessive compulsive disorder. But I don't think 10:27:06

that those are talked about in the DSM, per se. But in the broader literature it's very rare for -- for surgery to be involved in DSM diagnoses.
Q. BY MR. HILDABRAND: You already brought up the Brandt deposition, so if you want to bring -- 10:27:32 get that back out here. I think it was marked as Exhibit 5. (Sotto voce.)
Can you -- do you see on line 20 -- well, I'll wait until you get there.
MR. SELDIN: What page are you on? 10:28:08
MR. HILDABRAND: Page 79.
Q. So during the Brandt deposition you were asked, "Are there any other psychiatric diagnoses that you're aware of that were treated with surgery?" 10:28:32
And your answer was "no"?
A. Yes. That's correct.
Q. I think we've also used the Fain deposition transcript, if you want to pull it out. It should be Exhibit 8. Go to page 137. It should 10:28:53 be toward the end.
All right. So on page 137, if you look at lines 2 through 6.
So during the deposition in Fain, were you asked, "Are you aware of any other DSM-V diagnosis 10:29:31

that is treated surgically?"
A. Yes.
Q. And was your answer to that question, "I cannot think of another DSM-V diagnosis that is treated surgically"? 10:29:45
A. Yes.
Q. And so do you agree that there are not other DSM-V diagnoses that are treated surgically?
MR. SELDIN: Object to form.
THE WITNESS: Well, I couldn't think of 10:30:03 one on those depositions.
[redacted]
10:30:49

[redacted]
10:32:56

[redacted] 10:33:37

Q. And gender incongruence is a diagnosis under ICD-11; is that right?

MR. SELDIN: I'm just going to -- I apologize for interrupting. If you're not asking any more questions about this particular patient, I think this can end the portion of the deposition that we're going to designate confidential. 10:33:53

MR. HILDABRAND: Yeah. After the -- of course you can send a note by email what -- in a letter what you want designated by confidential. 10:34:03

But I'm going to move away from those questions. So thank you for that statement.

Q. So is gender incongruence a diagnosis under ICD-11?

A. Yes. 10:34:21

Q. The United States doesn't use ICD-11; is that right?

A. That's correct.

Q. Does the United States use ICD-10-CM instead? 10:34:28

A. Yes.

Q. In contrast to gender dysphoria, gender incongruence does not require clinically-significant distress, right?

A. That's correct. 10:34:37

Q. And WPATH SOC8's criteria for hormonal and surgical treatments for adults and adolescents uses gender incongruence --

(Clarification by the reporter.)

Q. BY MR. HILDABRAND: Yeah. WPATH Standards of Care Version 8's criteria for hormonal and surgical treatments for adults and adolescents uses gender incongruence as the relevant diagnosis instead of gender dysphoria; is that right? 10:34:40

A. Yes. Though when they do talk about 10:35:07

initiating treatment, they talk about the presence of dysphoria as well.

Q. Let's go back to the WPATH standards of care. I think it was marked as Exhibit 7. We're going to go in this to S256, which, I think, is the third-to-last page. 10:35:34

Is this the Appendix D: Summary criteria for hormonal and surgical treatments for adults and adolescents?

A. Yes. This is for, yes, adults and adolescents. 10:36:03

Q. Right. So let's go -- let's start here down on the bottom left. It's the summary criteria for adults?

A. Yes. 10:36:15

Q. It has criteria for hormones.

Do you see that?

A. Yes.

Q. And so for A, the A criteria is "Gender incongruence is marked as sustained," right? 10:36:21

A. Yes. Yes.

Q. And B, the criteria is "Meets diagnostic criteria for gender incongruence prior to gender-affirming hormone treatment in a region where a diagnosis is necessary to access 10:36:37

healthcare"; is that right?

A. Yeah. So that -- when they're referring to regions where a diagnosis is necessary to access healthcare, that includes the gender dysphoria diagnosis in the -- in the United States. 10:36:54

So most of the rest of the world is using gender incongruence. But the diagnosis that's necessary to access care for the United States is gender dysphoria.

Q. It doesn't mention expressly gender dysphoria, though, correct? 10:37:13

A. Well, in other parts of the DSM it does talk about the presence of dysphoria. And I believe the medical necessity part talks about the presence of having -- of dysphoria. 10:37:29

So they were trying to make it international by using gender incongruence. But they -- they do say where a diagnosis is necessary, and we don't have gender incongruence as a diagnosis in the U.S. 10:37:54

And so the understanding is that that diagnosis is gender dysphoria in the U.S.

Q. You say it's the understanding. But for B, to be clear, it does not mention gender dysphoria, correct? 10:38:07

A. There, but else -- elsewhere in associated it does talk about gender dysphoria.
Q. So in Appendix D, "Criteria for Hormones," B, it does not mention gender dysphoria, correct?
MR. SELDIN: Object to form. This is summary criteria. 10:38:26
You can answer.
THE WITNESS: Yes. It is the summary criteria, and it does -- it just mentions gender incongruence under the "Criteria for Hormones" here. 10:38:37
Q. BY MR. HILDABRAND: And did your counsel just tell you that it's summary criteria?
A. Well, he said it, but I noticed that. I knew that that was the case as well, so... 10:38:49
MR. SELDIN: And I'll note for the record that this was introduced as Appendix D, summary criteria for hormonal and --
MR. HILDABRAND: Yes. But counsel for plaintiffs is not testifying in this case. So I'd ask you to please limit your objections to not substantively testify for the witness. 10:39:02
Q. Can you point me to where in WPATH SOC8 it includes gender dysphoria as a requirement for this B? 10:39:16

A. So they mention the presence of dysphoria. But the -- when they talk about criteria, there was a decision to use gender incongruence because ICD-11 is the diagnostic criteria in the rest of the world. Gender dysphoria, which is DSM-V and codes to IC-10-CM in the United States, is our -- our diagnosis. 10:39:40
So I know at least in the -- in the discussion of this, the understanding was that the diagnosis codes to -- is gender incongruence outside of the U.S., but the diagnosis that's required in the U.S. is -- is the diagnosis that we use of gender dysphoria. 10:40:02
Q. But this page and no other page in WPATH SOC8 refers to that understanding, correct? 10:40:21
MR. SELDIN: Object to form.
THE WITNESS: They do refer to -- they do, like -- let's see. Page 57 says, "While gender dysphoria is still considered a mental health diagnosis in the DSM-V-TR, the American Psychiatric Association, gender incongruence is no longer seen as a pathological or a mental disorder in the world health community." 10:40:46
And so where this can have some importance is if someone has gender dysphoria and they're 10:41:17

treated with hormones and they no longer have gender dysphoria because they no longer have distress that's sufficient to impair social occupational functioning or to be clinically significant, so they're no longer meeting the DSM criteria, but they still need hormones to maintain that state. 10:41:39
And so the -- within the rest of the world, a clinician is not necessarily making a mental health diagnosis, but, rather, they are maintaining that person on their hormones even if they don't have clinically-significant distress. But let's see... 10:42:01
Q. BY MR. HILDABRAND: And so you pointed me to page 57. Page 57 does not say that in the United States gender dysphoria is a requirement before prescription of hormones, right? 10:42:17
A. Let's see. So -- so as I said, there are -- there are -- they did make the decision in -- it says here, 8, to use the international criteria. But that doesn't mean that Standards of Care 8 are not -- there's -- there's not application to -- to people in the United States who are receiving a different diagnosis. 10:42:52
So they do talk about -- again, in -- 10:43:26

let's see -- S15 talks about in the United States they use gender dysphoria, focusing on distress. And let's see. Where is --
Q. I hate to interrupt you. Before we get to another page, to be clear, page 15 does not say that gender dysphoria is required before prescription of hormones in the United States, correct? 10:43:53
MR. SELDIN: Dr. Karasic, were you done with your prior answer? 10:44:04
THE WITNESS: That's correct.
But it does say, for example, then on that same section on S17, "However, gender incongruence that causes clinically significant distress and impairment often requires medically necessary clinical interventions." 10:44:18
And so "In many countries, medically necessary gender-affirming care is documented by the treating health professional as treatment for gender incongruence and/or as treatment for gender dysphoria." 10:44:37
And so they do refer to -- there's the broader referring of gender incongruence as the international diagnosis. But it's also clear within the United States' context that that 10:44:54

diagnosis is gender dysphoria.
Q. BY MR. HILDABRAND: Page 17 of WPATH's Standards of Care Version 8 does not say that gender dysphoria is required before prescription of hormones, correct? 10:45:08
MR. SELDIN: Object to form.
Q. BY MR. HILDABRAND: In the United States?
A. Standards of Care 8 is referring to internationally. But it does say that gender incongruence that causes clinically-significant 10:45:22
distress and impairment often requires medically-necessary clinical intervention.
So they are -- within Standards of Care 8, they are accommodating the diagnostic criteria within the United States, but they're also using 10:45:40
this broader criteria that's used internationally.
Q. So to be clear, page 17 of the WPATH Standards of Care Version 8 does not say that a gender dysphoria diagnosis is required before prescription of cross-sex hormones in the United 10:45:57
States?
MR. SELDIN: Object to form. Asked and answered.
THE WITNESS: So it does not specifically say that. 10:46:09

Q. BY MR. HILDABRAND: Okay. Let's go back to the summary criteria. And, of course, in your answers, feel free to pull up something that's more specific. But in -- on page 256, "Criteria for Surgery," the A criteria for surgery for adults is 10:46:24
"gender incongruence is marked and sustained," right?
A. Yes.
Q. The 8 criteria here does not reference gender dysphoria, right? 10:46:47
A. Yes.
Q. And for B, under "Criteria for Surgery," it says, "Meets diagnostic criteria for gender incongruence prior to gender-affirming surgical intervention in regions where a diagnosis" -- 10:46:57
"diagnosis is necessary to access healthcare," right?
A. Yes.
Q. And Criteria B here does not expressly mention gender dysphoria, correct? 10:47:05
A. It mentions gender incongruence. It uses the international diagnostic criteria.
Q. And then going down to "Summary Criteria for Adolescents," do you see where it has "puberty-blocking agents"? 10:47:21

A. Yes.
Q. So under the criteria for puberty-blocking agents, WPATH's A criteria is that "gender diversity/incongruence is marked and sustained over time," right? 10:47:41
A. Yes.
Q. And then the B criteria for WPATH for prescription of puberty-blocking agents is "meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access 10:47:49
healthcare," right?
A. Yes.
Q. And what's gender diversity?
A. So here they're referring to -- so in -- in someone receiving puberty blockers, they may be 10:48:05
just a Tanner stage 2, and so they may have been observed to -- to be gender different in some way in childhood without having a diagnosis of gender incongruence of adolescence and adulthood until they reach, you know, Tanner stage 2, and that's 10:48:34
adolescence.
Q. Let's move on to page 860 -- this is page 527 here.
A. Okay.
Q. Do you see where it has the criteria for 10:48:48

adolescents' prescription of hormonal treatments?
A. Yes.
Q. So WPATH's A criteria for hormonal treatments for adolescents is "gender diversity/incongruence is marked and sustained over 10:49:02
time"?
A. Yes.
Q. And the B criteria is "meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access 10:49:14
healthcare"?
A. Yes.
Q. And then do you see where WPATH lists its criteria for surgery for adolescents?
A. Yes. 10:49:22
Q. And so the A criteria for surgery for adolescents is "gender diversity/incongruence is marked and sustained over time," right?
A. Yes.
Q. And the B criteria is "meets the 10:49:32
diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access healthcare"?
A. Yes. And again, they're -- they are including the United States where the diagnosis is 10:49:49

gender dysphoria.
Q. And again here, B does not mention gender dysphoria, correct?
A. Correct.
Q. And the authors at WPATH were aware that gender incongruence is not -- you're an author of the WPATH standards of care? 10:49:59
A. Yes.
Q. And you're aware that gender incongruence is not a diagnosis used under the ICD-10, correct? 10:50:11
MR. SELDIN: Object to form.
THE WITNESS: I'm sorry. What was that?
Q. BY MR. HILDABRAND: You're aware that gender incongruence is not a diagnosis under ICD-10? 10:50:23
MR. SELDIN: Same objection.
THE WITNESS: That's -- that's correct, because it was an international committee. They -- they chose to use the IC-11 criteria as opposed to IC-10. But the understanding -- and I don't think I can pick this out, this -- you know, from -- fully from here from this time. 10:50:36
But certainly mentioned about having dysphoria in -- when they talk about medical necessity of care of an intervention, the -- that 10:50:58

in the United States that diagnosis is gender dysphoria because that's the diagnosis that we use.
Q. BY MR. HILDABRAND: And you can't point me to any part of the WPATH's Standards of Care Version 8 that says that gender dysphoria is a requirement before the provision of gender-affirming surgery in the United States, correct? 10:51:12
MR. SELDIN: Object to form.
THE WITNESS: So they -- they refer -- they -- it's an international document, and so they are trying to use international terminology. 10:51:23
Q. BY MR. HILDABRAND: The document refers to the United States in several points, correct?
A. Yes. But, for example, you know, it -- it's certainly possible at some time in the very distant future that the United States could adopt IC-11, you know, probably -- well, we take about 20 years after the rest of the world. That will probably be standards of care 9 or 10. 10:51:38
But there was an editorial decision that they made rather to -- rather than use "gender dysphoria" and "gender incongruence," to just say "gender incongruence" through the document. 10:51:59
Q. And the document also does not say -- 10:52:18

(Clarification by the reporter.)
Q. BY MR. HILDABRAND: The document also does not say that gender dysphoria is necessary before provision of gender-affirming surgery in the United States, correct? 10:52:31
MR. SELDIN: Object to form.
THE WITNESS: It does mention dysphoria when they talk about the medical necessity of an intervention.
Q. BY MR. HILDABRAND: Can you identify for me where in WPATH Standards of Care Version 8 it says that gender dysphoria is a necessary diagnosis for the provision of gender-affirming surgery in the United States? 10:52:42
MR. SELDIN: Object to form. 10:52:57
THE WITNESS: When -- when standards of care makes statements like that, they use "gender incongruence," not "gender dysphoria." As I said, that was an editorial decision, because the United States is one country and the rest of the world are -- you know, many other countries that have members of WPATH, and we use Standards of Care 8 as well. 10:53:09
Q. BY MR. HILDABRAND: So was it an editorial decision not to say that gender dysphoria is a 10:53:21

necessary diagnosis before provision of gender-affirming surgery in the United States?
MR. SELDIN: Object to form. Asked and answered. Misstates testimony.
THE WITNESS: So they did -- when -- at -- at certain times in Standards of Care 8 they do refer to dysphoria, including when they're talking about the medical necessity of an intervention. They talk about the presence of dysphoria as part of that. 10:53:33
But when they're making the criteria, they use gender incongruence. 10:53:49
Q. BY MR. HILDABRAND: Just yes or no. You cannot point me to any part of WPATH's Standards of Care Version 8 that requires a diagnosis of gender dysphoria before provision of a gender-affirming surgery in the United States? 10:54:02
MR. SELDIN: Object to form. Asked and answered. Misstates testimony.
THE WITNESS: As I said, they opted in their list of criteria to use "gender incongruence" rather than saying "gender incongruence" and "gender dysphoria" in the U.S. But -- and in -- I think in previous iterations, they said, "Meets diagnostic criteria according to local context," 10:54:14 10:54:32

which made it clearer that -- that it's different in the United States than the rest of the world.

Q. BY MR. HILDABRAND: And I hate to do this, but I really need a yes-or-no answer here.

Can you identify a page in WPATH's Standards of Care Version 8 that requires a diagnosis of gender dysphoria before provision of gender-affirming surgery in the United States? 10:54:46

MR. SELDIN: Object to form. Asked and answered. Misstates testimony. 10:54:59

THE WITNESS: Yeah. They don't list criteria specifically for the United States.

Q. BY MR. HILDABRAND: Thank you.

Do you agree that some people's gender identity changes or evolves over the course of development or course of a lifetime? 10:55:24

A. So in general, people's gender identity is quite stable over a lifetime. But I'm not denying the existence of detransitioners of people who -- who do have -- who do report a change in their identity, sometimes even as they still report having gender dysphoria. But they -- they don't describe themselves the same way as they did before transition. 10:55:48

Q. So you agree that for some people, their 10:56:07

gender identity can change over time?

MR. SELDIN: Object to form.

THE WITNESS: I think it's very uncommon. And what's striking, as I've worked with people for over 30 years, how people's -- how persistent people's gender identity is. 10:56:20

There are people who over time, especially nonbinary people, who will have a different descriptor. It may have been gender queer in their previous era, and now they may -- they may say nonbinary. And so there -- there are people who report. 10:56:44

And we make clinical diagnoses of gender dysphoria. But people come to us or report in, you know, the media or in their blogs or wherever, you know, what their gender identity is, and there are people that report that has changed. 10:57:12

I -- in terms of my patients, I certainly have some gender-fluid patients who sometimes identify as more masculine and sometimes identify as more feminine within kind of a nonbinary umbrella. 10:57:31

MR. HILDABRAND: I'm going to enter this as -- I think we're on Exhibit 9 now.

(Reporter marked Exhibit Number 9 10:57:42

for identification.)

Q. BY MR. HILDABRAND: You mentioned Brandt v. Rutledge earlier.

Did you also testify at trial in Brandt v. Rutledge? 10:58:00

A. Yes.

Q. Is this a transcript of the day you testified in that case?

A. Yes.

Q. And you testified under oath at trial in Brandt v. Rutledge; is that right? 10:58:05

A. Yes.

Q. Let's go to page 31. Sir, were you asked, "is it possible that someone's gender identity can change or their understanding of their gender identity can change over time?" 10:58:32

And then you answer --

A. I'm sorry. Where -- where are you looking?

Q. Yeah. So let's -- let's see. So I think actually it starts on the previous page, on page 30 -- 10:58:42

A. Okay.

Q. -- line 25, "Q," it says, "You testified that people can't voluntarily change their gender 10:58:50

identity, but is it possible that someone's gender identity can change or their understanding of their gender identity can change over time?"

Were you asked that question on direct examination? 10:59:04

A. Yes.

Q. And was your answer down starting at line 7, that "for most people, gender identity is quite stable, but some people evolve in their gender identity over the course of development or course of a lifetime"? 10:59:14

A. Yes.

Q. And do you agree with that statement today?

A. Yes. 10:59:29

Q. All right. Let's go back to your declaration. Let me go to paragraph 31. Sorry. A lot of documents. This is going to be the part of paragraph 31 that's on page 8.

Do you see where you say, "Gender identity, which has" a -- "which has biological bases, is not a product of external influence and not subject to voluntary change"? 11:00:15

A. Yes.

Q. So you're not aware of gender identity 11:00:25

changing based on an external influence; is that right?
A. So I -- I think what's been put out there in terms of in -- in the media of people becoming trans because they've been exposed to another trans person, for example, that has not been my experience with my patients. 11:00:45
So I think that people's kind of understanding might affect the labels that they give to themselves. But -- but gender identity is this very stable core that is not catching or, you know, easily changeable, you know, as -- it's clear from the many decades of people receiving psychotherapy to try to change their gender identity, people are very motivated to change their gender identity, but were unable to do so. 11:01:17 11:01:44
Q. So you're not aware, for example, a child first expressing a nonbinary or transgender identity after meeting a nonbinary or transgender person? 11:02:01
MR. SELDIN: Object to form.
THE WITNESS: So when you talk about children, they -- in those circumstances, typically, they have already been having experiences that -- you know, where they might be 11:02:17

labeled as gender diverse. There is -- they're not -- they don't, you know -- they're not born and, you know, at the same time sex is assigned at birth, they say, "But my gender is"...
You know, there's a process of development through childhood where they might figure things out. And so sometimes that could be that they need someone who -- who identifies in a certain way and then, you know, might try on that -- that label. 11:02:38
Q. BY MR. HILDABRAND: Let's go down to paragraph 57. It's on page 16. And you cite several articles here in paragraph 57, and one of them is Brik, et al., 2020; is that right? 11:03:06
A. Yes.
Q. And just for transcribing, Brik is B-r-i-k. 11:03:33
A. Yes.
Q. And you've read that article several times before, right?
A. Yes. 11:03:45
Q. And Brik 2020 report that one adolescent identified at birth as male stopped gender-affirming medication after falling in love with a girl and desisted from his transgender identity, right? 11:03:58

MR. SELDIN: Object to form.
THE WITNESS: That's -- would be my recollection, is that their -- yeah. I would have to have it in front of me to say definitively, but -- but that is my recollection. 11:04:17
MR. HILDABRAND: Let's do that, then. We'll mark it real fast, and I'll give it to you here.
(Reporter marked Exhibit Number 10 for identification.) 11:04:46
Q. BY MR. HILDABRAND: All right. So is this, what's been marked as Exhibit 10, Brik --
A. Yes.
Q. -- 2020?
A. Yes. 11:04:52
Q. Let's turn to page 2615. Do you see on the bottom right of this page here where it says, "For one adolescent, the experience of falling in love made him doubt whether he was transgender. This is in line with previous findings of the first romantic experiences and the awareness of one's sexual attraction playing an important role in the resolution of dysphoria in adolescents"? 11:05:19
A. Yes. But can you tell me -- I just want to find where you -- where that is. 11:05:36

Q. Yeah. It's here, page 26 --
A. Oh, here at the last paragraph. Okay. I see. Sorry.
Q. So you agree that's what the article says here? 11:05:44
A. Yes. That's from, yeah, a -- an article by Steensma in 2011 from a kind of qualitative, I think, perspective on the youth that we're seeing in the -- in the Dutch program.
Q. So you mean -- just to be clear, when you say "that," you are referring to the statement that "the first romantic experiences and the awareness of one's sexual attraction play an important role in the resolution of gender dysphoria in adolescents"? 11:06:09 11:06:25
A. Yes. I'm saying that that, I believe, is an assertion by Steensma in 2011 that they're referring to in that as -- that this one adolescent, that that was a -- you know, an example. And so, you know, this does say -- it says 1.9 percent of the 333 adolescents did stop taking medication. 11:06:52
Q. We'll get back to that in a second.
So do you agree with the statement that the first romantic experiences and the awareness of 11:07:11

one's sexual attraction play an important role in a resolution of gender dysphoria in adolescents?
MR. SELDIN: Object to form.
THE WITNESS: No. I think that's -- that's an assertion that's been made. I don't really know if -- you know, how common that is. 11:07:26
Q. BY MR. HILDABRAND: Do you agree that that happens for some individuals, that the first romantic experiences and the awareness of their sexual attraction played an important role in the resolution of gender dysphoria? 11:07:51
MR. SELDIN: Object to form.
THE WITNESS: That hasn't been my experience with my patients, that -- that it's very rare for there to be a resolution of gender dysphoria in adolescents. And I haven't seen that particularly in patients of mine. 11:08:08
I was aware of a colleague's patient years ago who detransitioned as a result of a romantic relationship and -- and was someone who was assigned male at birth, who transitioned and was living as female, got into a relationship with a heterosexual woman, detransitioned as a result. But that person continued to have gender dysphoria. 11:08:35
So, you know, even under -- I mean, that's 11:09:00

a different circumstance that that happened to that person as an adult. But the gender dysphoria, you know, persisted in that case even with a romantic relationship. So I -- I know that that has been asserted, but I don't know if that is -- is the case in any, you know, broader way. 11:09:22
Q. BY MR. HILDABRAND: Just to make sure I'm understanding. So that person still had gender dysphoria in adult -- in adults even after detransitioning? 11:09:37
A. Right. So that person detransitioned and -- so lived as male but would in private dress as female to try to address their gender dysphoria. So they -- they still had the gender dysphoria. They just identified as male for the sake of their relationship and when they were with their spouse. 11:10:03
Q. And you also mentioned a 1.9 percent rate. Did Brik 2020 also exclude the nine children or adolescents who had stopped attending appointments? 11:10:24
A. Yes, I assume so. But if you look at Cavve, which I cite in my declaration from Perth, from Western Australia, they were able to track down almost everyone, because Western Australia, during a big part of that time it was the -- there 11:10:53

was COVID. So you couldn't actually even leave western -- or enter Western Australia.
Anyway, it's very remote, among the most remote cities in the world, and so they were able to track down almost everyone. And they found only two out of approximately 200 of the people who had started puberty blockers or hormones in their clinic who had left the clinic, had stopped treatment because of reidentification with their birth sex. So that was 1 percent. So again, it can happen, but it's quite uncommon. 11:11:11 11:11:34
Q. We'll get to Cavve in a second. But for Brik 2020, it also excluded children and adolescents who did not want hormonal treatments; is that right? 11:11:55
MR. SELDIN: Object to form.
THE WITNESS: Yeah. It says 3.5 percent no longer wished gender-affirming treatment.
Q. BY MR. HILDABRAND: And so for Cavve as well -- well, we can get to that in a little bit. 11:12:08
Let's go to paragraph 55 of your declaration first.
MR. SELDIN: Counsel, I think we're coming up on another hour.
MR. HILDABRAND: Then that's all the more 11:12:23

reason to take a break.
So let's go off the record then.
THE VIDEOGRAPHER: We're off the record. The time is 11:11 a.m.
(The noon recess was taken.)
---o0o---

SAN FRANCISCO, CALIFORNIA, OCTOBER 25, 2024
AFTERNOON SESSION
---o0o---
THE VIDEOGRAPHER: Okay. We're on the record. The time is 11:47 a.m. 11:48:10
Q. BY MR. HILDABRAND: All right. Doctor, other than lunch, did you discuss anything with counsel during the break?
A. No.
[redacted]
Q. Okay. Have any of your adolescent patients been treated with surgery for a DSM-V diagnosis other than gender dysphoria?
A. No. 11:48:44
Q. Now let's go to your declaration to paragraph 55.
A. I'm sorry.
Q. Sorry. Page 14, paragraph 55.
A. Yes. 11:49:06

Q. Do you see this line that "over 50 years of gender-affirming surgery in Sweden, the regret rate as measured by legal gender change reversal was 2 percent," citing Dhejne, et al., 2014?
A. Yes. Dhejne. 11:49:22
Q. Dhejne. Okay. And for the reporter, that's D-h-e-j-n-e.
Was it Dhejne; is that right?
A. Dhejne, like from Denmark.
Q. Thank you. The Swedish data in Dhejne 2014 would not have captured patients who simply lived with regret without reapplying to legally reverse their gender- -- 11:49:34
A. Correct.
Q. -- affirming surgery? 11:49:56
MR. SELDIN: Object to form.
THE WITNESS: That's correct.
Q. BY MR. HILDABRAND: And the 2 percent Swedish regret rate also would not include people who died or committed suicide before applying for a legal gender change; is that correct? 11:50:01
MR. SELDIN: Object to form.
THE WITNESS: That's correct.
Q. BY MR. HILDABRAND: At the time you wrote your declaration in this case, you knew about those 11:50:10

ways in which the 2 percent was an understatement of the Swedish regret rate, right?
MR. SELDIN: Object to form.
THE WITNESS: Well, one can also look at it over time. It is over 50 years. And the last decade they reported, they only had 0.3 percent regret. Most of the regret was earlier in that period. So there's a lot of ways to look at that data. 11:50:22
But I think saying a 2 percent regret rate is -- you know, is a reasonable way of looking at it, particularly then when you're including it with Bustos's systematic review and meta-analysis, you know, finding 1 percent across a whole bunch of different studies. 11:50:40 11:51:14
Q. BY MR. HILDABRAND: A couple follow-up questions. So am I correct, your declaration only mentions Sweden when discussing this 2 percent regret rate?
A. Yes. 11:51:21
Q. And do some individuals express regret many years after applying for a legal gender change?
MR. SELDIN: Object to form.
THE WITNESS: You -- oh, you mean after 11:51:32

applying the first time for legal gender change? There are people who are -- are you saying in Sweden or generally?
Q. BY MR. HILDABRAND: In Sweden. Might some individuals express regret about their legal gender change many years after that occurs? 11:51:55
MR. SELDIN: Object to form.
THE WITNESS: Yes. And so this would capture if they -- you know, however many years up to 50 after their -- after their surgery. 11:52:13
So it captures the data in a different way because it is looking at a whole population, and over 50 years, there's, you know, just many different ways of trying to, you know, get some idea of what that percentage might be. 11:52:32
Q. BY MR. HILDABRAND: Are you aware that Sweden has adopted guidelines for gender-affirming care that are very different from the WPATH guidelines?
MR. SELDIN: Object to form. 11:52:43
THE WITNESS: So the government of Sweden has -- has made some recommendations. And I'm happy to -- if you're presenting something or is that --
Q. BY MR. HILDABRAND: Oh, no. Finish your 11:53:02

answer. Sorry.
A. Yeah. Though I would say that -- that young people in Sweden are continuing to get puberty blockers when clinically indicated. The government report -- there was a government report 11:53:22
labeling puberty blockers as experimental and to be given in exceptional circumstances as determined by a clinical evaluation.
And everyone in Sweden and, I think, most places would have a clinical evaluation before 11:53:44
puberty blockers. So it has not prevented people, young people, in Sweden from getting puberty blockers.
Q. All right. Let's look at what we marked as Exhibit 5. This is the Brandt deposition. If 11:53:57
you will pull that out and turn to page 93.
MR. SELDIN: I think that's the Brandt trial. If you want the dep.
MR. HILDABRAND: Yep.
MR. SELDIN: Is that one over there, 11:54:16
Brandt?
THE WITNESS: Yes.
Q. BY MR. HILDABRAND: Let's look at page 93, lines 12 to 16. So were you asked the question, "And so -- so Sweden has adopted guidelines that 11:54:36

are very different from the WPATH guidelines; correct?"
A. Correct.
Q. And your answer was "Correct"?
A. Yes. 11:54:46
Q. And let's go to -- further down the page, were you also asked the question, "Okay. And these are more restrictive guidelines; correct?"
A. Yes.
Q. And your answer was "Correct"? 11:54:59
A. Yes.
Q. You don't need to describe it, but am I correct that your declaration in this case also does not mention the Cass Review?
MR. SELDIN: Object to form. 11:55:15
THE WITNESS: That's correct.
Q. BY MR. HILDABRAND: Do you agree that the Cass Review of gender-affirming care is relevant to understanding the provision of gender-affirming care? 11:55:31
MR. SELDIN: Object to form.
THE WITNESS: I think it's relevant to the provision of gender-affirming care in the United Kingdom.
Q. BY MR. HILDABRAND: But you don't think 11:55:40

it's relative to the provision of gender-affirming care in the United States?
A. Well, it's a very particular document, a government-commissioned report. Not -- they're not practice guidelines. It is a government 11:55:57
recommendation within their -- of care within their national health service.
Q. Do you agree that the experience of mental health providers around the world is relevant to the provision of gender-affirming care in the 11:56:10
United States?
MR. SELDIN: Object to form.
THE WITNESS: Yes. But the Cass Review was not driven by the mental health providers working with trans youth in -- in the United 11:56:22
Kingdom. More generally, it's hard to know everyone who was involved because their process and their authors are opaque.
But I do know that many of the people who were providing that care in the United Kingdom were 11:56:43
not part of the process of the Cass Review, so I view it certainly as some kind of a governmental response.
Q. BY MR. HILDABRAND: Did the WPATH Standards of Care Version 8 identify everyone who 11:56:58

provided comments on the WPATH Standards of Care Version 8?
MR. SELDIN: Object to form.
THE WITNESS: So Standards of Care 8 -- Standards of Care 8 identified all of the authors. 11:57:13
The Cass Review does not.
Q. BY MR. HILDABRAND: Did any U.S. government officials review or provide comments on WPATH Standards of Care Version 8?
MR. SELDIN: Object to form. 11:57:26
THE WITNESS: The WPATH Standards of Care 8 process happened without outside input up until the 2021 release for public comment. In 2021 there was a -- as part of the process, there was a request for public comment and a commitment to try 11:57:57
to be responsive to that.
And so I wasn't a part of the comments that you're referring to because I wasn't on the adolescent chapter, but I know on the mental health chapter, we were encouraged to review those 11:58:12
comments. And, you know, if any -- if anything needed to be addressed, that -- that people outside the committee hadn't marked but were identified by the public, that that was part of the process, was to try to incorporate public comment on that. 11:58:32

Q. BY MR. HILDABRAND: Did the WPATH Standards of Care Version 8 as published identify any U.S. government official who provided comments on the standards?
MR. SELDIN: Object to form. 11:58:43
THE WITNESS: No.
Q. BY MR. HILDABRAND: And were U.S. government officials only provided the same November 2021 version of the WPATH standards of care that other members of the public were 11:58:57
provided?
MR. SELDIN: Object to form.
THE WITNESS: I don't know.
Q. BY MR. HILDABRAND: Earlier today you mentioned Cavve 2024, right? 11:59:09
A. Yes.
Q. And that study examined outcomes for 558 -- sorry, 548 youth; is that right?
A. Yes.
Q. And if you want to look at paragraph 54, I 11:59:18
think this is one of the places you discuss it.
A. Excuse me while I -- let me just do this so I --
(Discussion off the record.)
THE WITNESS: Yes. 11:59:43

Q. BY MR. HILDABRAND: Your declaration, paragraph 54, you say here that "of 196 youth who are started on puberty blockers or hormones only two (1 percent) discontinued medical treatment because of reidentification with birth sex." 12:00:02
A. Yes.
Q. And a higher proportion of youth referred to the gender clinic but you did not start puberty blockers or hormones reidentified with their birth sex; is that right? 12:00:16
MR. SELDIN: Object to form.
THE WITNESS: Oh, the people who did not start, yeah, I don't remember the percentage, but perhaps -- perhaps you do.
Q. BY MR. HILDABRAND: So the 196 youth that 12:00:29
you refer to here, those are just the individuals who started puberty blockers or hormones; is that right?
A. Yes.
Q. And so the rest of that 548 youth did not 12:00:37
begin puberty blockers or hormones; is that right?
MR. SELDIN: Object to form.
THE WITNESS: Yeah, I assume that the others did not.
Q. BY MR. HILDABRAND: And you didn't provide 12:00:49

the reidentification rate for the individuals who did not start puberty blockers or hormones, correct?
MR. SELDIN: Object to form.
THE WITNESS: Correct. Because this 12:00:58
number was the number who -- that I provided were the people who discontinued medical treatment. So they looked at those who started treatment. They tried to follow up with them, and they found that a small percentage had discontinued medical 12:01:21
treatment. And of those, only two discontinued treatment because of identification with birth sex.
Q. BY MR. HILDABRAND: And are you aware of any author of Cavve 2024 who has acknowledged that the article may understate reidentification rates? 12:01:41
MR. SELDIN: Object to form.
THE WITNESS: No.
MR. HILDABRAND: I will enter this as Exhibit 11, I think is what we're on.
(Reporter marked Exhibit Number 11 12:01:49
for identification.)
Q. BY MR. HILDABRAND: Does this look like a printout of the article key points, abstract, and information from the JAMA Network?
A. Yes. 12:02:14

MR. SELDIN: And, Counsel, is this -- I know you just identified it, but to be clear, this is not the full article?
MR. HILDABRAND: No. Yes, this is the printout of where the article is at at the -- you 12:02:23
see the https address at the top of the page?
MR. SELDIN: Okay. But not the full article?
MR. HILDABRAND: This is not the full article itself. 12:02:31
MR. SELDIN: Okay. Thank you.
Q. BY MR. HILDABRAND: Do you see on -- do you want to turn to -- I think it's page 4.
A. Yes.
Q. Do you see that there's some comments on 12:02:44
the article?
A. Yes.
Q. And the reason for this is -- the primary purpose of the article. So I want to talk about the comments here today. So you see -- 12:02:53
A. And these are comments when it's on the JAMA -- JAMA Network website?
Q. Yes. I will represent to you that that's what these are here.
So you see the first one appears to be a 12:03:08

comment from a Sarah Jorgensen?
A. Yes.
Q. And for the transcript, that's J-o-r-g-e-n-s-e-n.
And then if you want to turn to page 5. 12:03:21
Do you see that there is a March 13th, 2024, comment from Blake Cavve?
A. Yes.
Q. Have you read this comment before?
A. I don't recall. 12:03:37
Q. Is Blake Cavve the primary author?
A. Yes.
Q. All right. Let's go to page 6, I believe. I want to ask about the comment here.
Do you see, mostly down the page, where he 12:04:01
says, "It is possible that a small number of active patients may have expressed feelings of reidentification Jan-Dec 2020 and may not have been closed"?
A. Yes. So this paper was only following up 12:04:20
with people who have closed out their care in the clinic. And so I assume he's saying that it's possible that there are a small number of people who are still in the clinic but may have reidentified with their birth sex. 12:04:37

Q. So is it possible for this study that some individuals could have continued mental health appointments after the reidentification and not been closed?
MR. SELDIN: Object to form. 12:04:50
THE WITNESS: Yeah. He says it's possible that there's a small number of those -- of those patients.
Q. BY MR. HILDABRAND: Okay.
A. Who -- because the study was of those who 12:04:57
had closed out their care in the clinic.
Q. All right. Let's go up a little bit on the page. Do you see the paragraph that begins, "Therefore, while it is possible that for some patients the lack of engagement is due to 12:05:20
reidentification and hence we may underestimate total reidentification rates, this is limited to our estimate of those who reidentified before triage appointment and, to a lesser degree, those in the process of a multidisciplinary assessment"? 12:05:34
A. Yes.
MR. SELDIN: And I'll just note for the record that that paragraph continues, "This does not affect our estimates of reidentification following provision of gender-affirming medical 12:05:46

treatment."
Q. BY MR. HILDABRAND: Right. So here we're talking about not the 196, but we're talking about the rest of that 548 who did not receive puberty blockers and hormones; is that right? 12:05:58
A. Well, they do talk about, I think -- I think they may have some number about hormone -- here where it says, "Patients who reidentify with their birth-registered sex comprise 5.3 percent of all referral closures." 12:06:24
And so even though it was only 1 percent of those who started hormones, there were people, again, a small percentage, who perhaps during their assessment process or afterwards, you know, exploring their gender but, you know, in that 12:06:48
process, reidentified with their birth gender.
Q. And some individuals were removed from the study due to lack of engagement; is that correct?
MR. SELDIN: Object to form.
THE WITNESS: As I recall, though, they 12:07:08
did -- there were 552 closed referrals, and they were able -- yeah. If you look under "Results," a reason for closure was determined for 548.
And the reason that sticks out is that's extraordinarily rare in research for anything to be 12:07:25

able to have a -- you know, a reason why people left the clinic for 548 out of 552. That's very -- that's 99 percent, right?
Q. Is it -- is it your understanding that some individuals were removed from the study due to 12:07:45
lack of engagement?
MR. SELDIN: Object to form.
THE WITNESS: Can you show me that sentence where it says that?
Q. BY MR. HILDABRAND: I'm just asking what 12:07:57
your -- if -- if you don't know, you don't know.
A. I don't know.
Q. Okay. Thank you.
Let's go back to your declaration, paragraph 54. Do you see this sentence toward the 12:08:06
top of the paragraph where you say, "For example, in one study in the Netherlands, none of the youth who received puberty blockers, hormones, and surgery, and followed over an eight-year period expressed regret"? 12:08:28
A. Yes.
Q. And that study involved a cohort of 70 youth; is that right?
A. Yes.
Q. And you are aware that one of the youth in 12:08:36

that study actually died of complications from their gender surgery?
MR. SELDIN: Object to form.
THE WITNESS: Yes. They had a vaginoplasty using a colon, which they do in the Netherlands, but it's very rarely done here, and the person got sepsis from that. And that risk is one of the reasons why that's a quite rare surgery here in the United States. 12:08:49
Q. BY MR. HILDABRAND: And you did not mention that death anywhere in your declaration, right? 12:09:06
MR. SELDIN: Object to form.
THE WITNESS: No.
Q. BY MR. HILDABRAND: And of the 70 youth, 15 dropped out of the study due to nonparticipation; is that right? 12:09:12
MR. SELDIN: Object to form.
THE WITNESS: Yes. That's my understanding. 12:09:22
Q. BY MR. HILDABRAND: And of the 55 who participated fully, another 15 were missing some data; is that correct?
A. That sounds right.
Q. Do you know whether the youth involved in 12:09:33

DeVries 2014 received psychotherapy?
A. Yes. Well, psychotherapy was -- is offered in their -- in their program.
Q. So the youth involved in that study did receive psychotherapy? 12:09:52
A. I don't know the details in terms of if it was possible for them to decline psychotherapy or how often they had to see a therapist as part of that care.
Q. But your understanding is that psychotherapy was normally available for -- 12:10:08
A. It was available, I think, is my understanding, for people in this study.
Q. Let's go now -- skip ahead to paragraph 67. It's on page 19. 12:10:25
Am I correct that the only citation you provide for paragraph 67 is Owen-Smith 2018?
A. Yes.
Q. And Owen-Smith 2018 was a survey of only adults, correct? 12:10:51
A. Yes.
Q. And Owen-Smith 2018 also excluded individuals whose gender identity was the same as natal sex at the time of the survey, right?
MR. SELDIN: Object to form. 12:11:04

THE WITNESS: Yes.
Q. BY MR. HILDABRAND: Owen-Smith 2018 also excluded individuals who were receiving transgender care exclusively from mental health providers, right? 12:11:13
A. Yes. I believe it was of those who were receiving medical interventions.
Q. Now, let's go to paragraph 44 in your declaration.
And here do you provide WPATH standards of care requirements for pubertal suppression and cross-sex hormones for minors? 12:11:40
A. Yes.
Q. Am I correct that you have not studied how many healthcare providers in South Carolina use the WPATH Standards of Care Version 8? 12:11:53
MR. SELDIN: Object to form.
THE WITNESS: I have not studied healthcare in South Carolina.
Q. BY MR. HILDABRAND: Am I correct that you have not studied how many healthcare providers in South Carolina use the 2017 Endocrine Society guidelines? 12:12:03
MR. SELDIN: Object to form.
THE WITNESS: That's correct. 12:12:15

Q. BY MR. HILDABRAND: And for (c) here in paragraph 44 you say, "Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment"; is that right?
A. Yes. 12:12:31
Q. Assent requires the youth to be cognitively mature enough to make decisions and to have an understanding of future consequences; is that right?
A. Yes. 12:12:39
Q. Are 15-year-olds cognitively mature enough to make decisions about sexual intercourse?
MR. SELDIN: Object to form.
THE WITNESS: Can you repeat the question?
Q. BY MR. HILDABRAND: Yeah. Are 15-year-olds cognitively mature enough to make decisions about sexual intercourse? 12:12:54
MR. SELDIN: Object to form.
THE WITNESS: About consenting to sexual intercourse? 12:13:04
Q. BY MR. HILDABRAND: It's a great clarifier. Are 15-year-olds cognitively mature enough to decide to consent to sexual intercourse?
MR. SELDIN: Object to form.
THE WITNESS: I think that's young. 12:13:15

Q. BY MR. HILDABRAND: Are some 15-year-olds cognitively mature enough to decide to consent to sexual intercourse?
MR. SELDIN: Object to form.
THE WITNESS: Can you repeat the question? 12:13:29
Q. BY MR. HILDABRAND: Are some 15-year-olds cognitively mature enough to consent to sexual intercourse?
MR. SELDIN: Object to form.
THE WITNESS: It's not a -- that's not an 12:13:46
assessment for consent that I have ever made, so I -- but -- so I don't know if I would, you know, make a response to that.
I think certainly there are, you know, reasons for, you know, restriction of consent for 12:14:14
sex for minors generally.
Q. BY MR. HILDABRAND: You say "reasons for restrictions." Do you mean government prohibiting minors from being allowed to consent to sexual intercourse? 12:14:31
MR. SELDIN: Object to form.
THE WITNESS: So it's not -- it's more a prohibition of adults having sex with minors. And I think there are reasonable, you know, reasons for that. 12:14:51

There are minors who have sex with minors where -- you know, where government tends not to be involved in those decisions.
Certainly, hopefully, parental, you know, advice and parenting general -- generally might 12:15:14
inform, you know, good decision-making by the youth involved.
Q. BY MR. HILDABRAND: So do you think that some 15-year-olds are cognitively mature enough to decide with parental involvement in that decision 12:15:27
to have sexual intercourse with another minor?
MR. SELDIN: Object to form.
THE WITNESS: It's not an assessment I've ever made.
Q. BY MR. HILDABRAND: So you don't have an 12:15:38
opinion one way or another about that question?
MR. SELDIN: Object to form.
THE WITNESS: I would say that there are good reasons to be concerned about a 15-year-old consenting to sex. 12:15:56
Q. BY MR. HILDABRAND: But you cannot definitively say that 15-year-olds are not cognitively mature enough to decide to have sexual intercourse with another minor?
MR. SELDIN: Object to form. 12:16:09

THE WITNESS: Yeah, I think I've answered the question.
Q. BY MR. HILDABRAND: And are 15-year-olds able to have an understanding of the consequences of sexual intercourse? 12:16:27
MR. SELDIN: Object to form.
THE WITNESS: They -- the cognitive abilities of 15-year-olds certainly can vary. But there are reasons to be concerned about -- about their cognitive abilities consenting to it. But 12:16:45
I've never done that sort of cognitive assessment.
Q. BY MR. HILDABRAND: Are 15-year-olds cognitively mature enough to understand orgasm?
MR. SELDIN: Object to form.
THE WITNESS: I think that minors can 12:17:05
sometimes have pretty sophisticated understandings of sex from -- whether it's their reading or otherwise, whether or not they engage in sex.
So there are people -- I have patients, not that I talk about consent for sex with, but I 12:17:32
do have patients that age who have pretty mature cognitive abilities. I think there's -- and there are those who don't at all.
So I do think that there's a variation, but there's also just kind of a larger set of 12:17:58

concerns for minors consenting to sex and particularly consenting to sex for adults -- with adults and what -- what the consequences of that -- that may be.
Q. BY MR. HILDABRAND: Do you have any minor 12:18:14
patients who are -- have or had minor patients who are 15 years old or younger who were cognitively mature enough to decide to consent to sexual intercourse?
MR. SELDIN: Object to form. 12:18:26
THE WITNESS: I've never made that assessment. I'm just saying I do have 15-year-olds who are very cognitively mature and others who are not. So I think if you're in a more broader way, you know, making decisions where, first of all, 12:18:41
they're not consenting all of the -- they're only assenting and the parents are consenting.
When I work with youth, even in terms of adjusting antidepressant doses, I'm consulting with and getting the consent of the parents. 12:19:08
And so there is a -- an appreciation that there is a level of understanding that the parents can give, and that's why we need parental consent for every -- for every minor, even for quite small decisions, because we do respect that there are, 12:19:32

you know, limitations that minors have.
Q. BY MR. HILDABRAND: Do you agree that 15-year-olds are categorically incapable of assenting to sexual intercourse?
MR. SELDIN: Object to form. 12:19:49
THE WITNESS: I think you've asked me this question, like, a dozen times, and I've tried to answer it as best I can.
Q. BY MR. HILDABRAND: Yeah. I just want to make sure I understand your position as best I 12:19:58
could. You use consent, assent. I want to make sure I'm understanding it.
So can you answer the question?
A. I -- I think -- I think when you -- if you are trying to draw analogies to assent for medical 12:20:09
care for minors, you have to take into account that the parents are the ones giving the consent and the minors are assenting.
I don't think there's a rough equivalent where the parents are consenting to sex and the 12:20:28
minors are assenting for 15-year-olds. So I don't -- I'm not -- it's not a process that I am familiar with.
Q. And are 12-year-olds cognitively mature enough to understand orgasm? 12:20:42

MR. SELDIN: Object to form.
THE WITNESS: So I would -- I have minor patients where they have had long discussions with their therapists and with their parents about the potential consequences of care. A 12-year-old is 12:21:14
not going to assent without also the consent of parents and without kind of a process.
Q. BY MR. HILDABRAND: Yeah. And I just wanted to understand that process.
So can a 12-year-old of that age, are they 12:21:33
cognitively mature enough when providing that assent to understand what orgasm means?
MR. SELDIN: Object to form.
THE WITNESS: So they -- in the context of parental consent and extended discussions with -- 12:21:53
about consequences of care, they are -- minors can -- are able to assent for care. But their -- even though -- maybe you're referring to some comment that was made about minors having orgasm.
In -- in the actual research, if you look 12:22:42
at the Dutch data, there was an update on this data in Portugal recently. The -- that's eventually being published.
They found that minors who got -- in the Dutch cohort, minors who got puberty blockers were 12:23:12

-- at a young age, at 11, 12 years old, were actually more likely be able to orgasm or achieve sexual satisfaction than those who didn't get treated until they were late in adolescence.
And -- and so -- and in particular, when 12:23:40
you're looking at transgender girls, the -- and then they're -- this is longitudinal, so they're following up with them as adults when they are sexually active.
But they were looking at minors whose -- 12:23:59
in the Dutch cohort started puberty blockers early, those that started puberty blockers or hormones later in adolescence, presumably Tanner Stage 5 or later, and then they were also comparing them to cisgender women in the general population. 12:24:25
And the rate of orgasm and reaching -- having sexual satisfaction was -- was roughly the same. And it was actually more of the minors, 11, 12 years old, Tanner Stage 2, who got puberty
blockers did report good sexual satisfaction 12:24:51
compared to those that got -- had interventions later.
So, you know, would -- I mean, that's just that kind of data. So I'm not sure if, like -- in the question if there's, like, an assumption that 12:25:12

somebody is at 11 able to consent to say good-bye to sexual satisfaction forever, because that's not at least what the Dutch data shows.
And -- but there has been, you know, certainly, you know, discussion about, you know, 12:25:31
what people consent -- assent to, you know, at a young age, and it's certainly something that we, you know, had to think about and talk about.
Q. BY MR. HILDABRAND: Yeah. So a couple follow-up questions. First, you mentioned a 12:25:49
Portugal study.
Is that -- do you refer to that in your declaration?
A. The study was presented in Portugal.
Q. Okay. 12:25:57
A. And it was presented in Portugal. The conference was at the end of September, and so it was after the declaration. It was only, you know, in the past month.
However, the -- that data with a smaller 12:26:08
amount of data collected was presented also in Montreal at the WPATH in 2022. And there was a question in the audience of when it was going to be published. So I assume soon, but it's not yet been published. But you can see it as abstracts, 12:26:34

presumably, for the conferences.
Q. And one of those conferences was Montreal 2022; is that right?
A. Montreal was 2022 for WPATH, and then Portugal, Lisbon, is 2024. 12:26:45
Q. Thank you.
And so you'd agree that some gender-affirming treatments negatively impact the ability of an individual to achieve orgasms; is that correct? 12:26:58
MR. SELDIN: Object to form.
THE WITNESS: So whenever we provided a treatment -- the health practitioner provides a treatment, goes over risks and benefits of treatment. And so, you know, for an adult to be -- 12:27:15
if somebody is assigned male at birth and then they transition and they're taking an androgen-lowering drug along with estrogen, that can affect their sexual functioning. And so that's discussed with the patient. 12:27:44
Q. BY MR. HILDABRAND: When you say "affect," it could affect it negatively in some cases?
A. Yes.
Q. And again, am I correct that you have not studied informed consent practices of South 12:27:52

Carolina healthcare providers?
MR. SELDIN: Object to form.
THE WITNESS: That's correct.
Q. BY MR. HILDABRAND: Does the WPATH Standards of Care Version 8 require both parents to 12:28:00
consent to gender-affirming treatment or just one parent?
MR. SELDIN: Object to form.
THE WITNESS: So Standards of Care 8, it's not law. They are clinical guidelines, and those 12:28:15
guidelines are different in different countries. In some countries minors can assent for care at age 16; I believe in the U.K. and in the Netherlands.
In the U.S., people need to have parental 12:28:37
consent. Minors need to have parental consent for any kind of care other than, like, emergency care when someone is in a car accident and they can't find their parent.
But other than that situation, parents do 12:28:57
need to consent unless there's -- you know, it's a guardian, if they have a guardian, or except for, you know, a few cases where someone's an emancipated minor.
Q. BY MR. HILDABRAND: So -- so consent 12:29:12

practices vary based on the jurisdiction's laws; is that correct?
MR. SELDIN: Object to form.
THE WITNESS: Based on national laws. But in general in the United States, people do need, 12:29:23
you know, parental consent if they're getting gender-affirming care under the age of 18.
Q. BY MR. HILDABRAND: You said based on a national law. Is that --
A. No. National laws like of the U.K. and 12:29:39
the Netherlands, for example, are different from American law. So there are other countries that set different ages of consent than the United States. But the United States, in general, it is -- in general, it's 18. 12:29:58
And -- and certainly all the care that I provide when someone's under 18, I'm getting consent from -- from the parents. If there's -- if the parents are together and there's agreement that one of the parents is consenting, they may be the 12:30:21
only parent who's participating in the conversations, but the other parent still maintains the ability to object.
And I do have patients where one parent has objected, and that has kept the patient from 12:30:38

getting care that the other parent wanted or that -- you know, that the doctors have discussed.
Q. So is it your understanding, though, that that's a matter of federal law in the United States or a matter of state law regarding consent? 12:30:57
MR. SELDIN: Object to form.
THE WITNESS: My understanding is it's state law.
Q. BY MR. HILDABRAND: And you practice here in California; is that right? 12:31:05
A. Yes.
Q. And in California, California allows courts to authorize gender-transition procedures on minors when the minor is physically present in the state even if the parents do not consent; is that 12:31:15
correct?
MR. SELDIN: Object to form. Calls for a legal conclusion.
THE WITNESS: Yeah. There is -- there was, like, sanctuary law where -- but I am not 12:31:23
aware of -- I'm not fully aware of all the details of the law, and I'm not aware of any time that that has -- has happened.
You know, there have been a handful of cases where one parent -- where two parents 12:31:48

disagree in terms of care. Typically one parent the courts -- these are cases where people get divorced and where only one parent is caring for the -- their child.

And sometimes the Court has granted sole medical decision-making to that -- to that one parent. So there are circumstances uncommon, but they can happen where one parent consents without the other parent. 12:32:10

The ordinary care that I see is that both parents need to come to an agreement on what care is provided to their child. 12:32:28

Q. BY MR. HILDABRAND: Do you agree that gender-affirming treatment should not be provided to the minor when a parent does not consent to that treatment? 12:32:51

MR. SELDIN: Object to form.

THE WITNESS: So if both parents are legal decision-makers, then both of them need to consent.

As I said, there have been a few cases where one parent -- the courts have declared one parent as the decision-making parent, and that parent does get to make medical decisions for the child. 12:33:09

You know, one would like to think that 12:33:27

parents could get together and -- you know, to decide on care, and that is what happens when the parents are together.

But there are a few cases of divorce where the parents are not able to come to an agreement. 12:33:47

And I'm aware of, you know, a handful of cases when courts have -- have intervened and given the custodial parent the right to make the medical decision.

Q. BY MR. HILDABRAND: And so you don't see any problem in those cases of divorce or other circumstances where the Court has intervened to decide who should make the decision -- 12:34:03

MR. SELDIN: Object to --

Q. BY MR. HILDABRAND: -- for the child? 12:34:14

MR. SELDIN: Object to form.

THE WITNESS: So I think there are cases one parent is not involved in the child's life, that there may be -- and somebody needs to make a decision, because it is a decision either way, yes or no, to any intervention. And that's, you know, things that the courts have done in other types of medical care as well. 12:34:25

And so I think that, of course, there's the, you know, due process of law of the Court, you 12:34:42

know, considering those circumstances. Obviously those are not ideal circumstances, but there are times where, you know, one can imagine it might be necessary.

Q. BY MR. HILDABRAND: Do you view it as abusive toward a child to -- for a parent to refuse to affirm the child's asserted gender identity? 12:35:00

MR. SELDIN: Object to form.

THE WITNESS: So I think that when you have cases where parents don't want to accept their -- their child's identity and that -- and that's creating conflict that's brought to the mental health provider, that it is important that some family work or, you know, some sort is done to try to bring the family together. 12:35:20 12:35:47

And that sometimes can be important even in adults, where even though the adult seeking care -- the young adult seeking care has the full legal right to, you know, provide that care, they also may, you know, be part of a family where it's important to -- where it's helpful for the -- the young adult to, you know, remain part of that family. 12:36:06

And so trying to work with the family so that they can better understand each other and 12:36:24

communicate with each other and be respectful of each other, I think those are -- can be important -- important things.

Q. BY MR. HILDABRAND: So do you agree it's not abusive of a child for a parent to refuse to affirm a child's asserted gender identity? 12:36:35

MR. SELDIN: Object to form.

THE WITNESS: I -- I think it certainly happens in cases where the parents are not trying to be abusive. I think there are some cases where -- you know, where abuse can be part of it, whether it's physical abuse or throwing the child out of the house or -- you know, there can be kind of abusive practices. 12:36:55

I think that -- though, that the person who might be transitioning or considering transitioning has been thinking about doing that for -- often for a very long time, and the parent may just be hearing about it. And they may need to have their own process in terms of even figuring out what to do. 12:37:18 12:37:36

And so, you know, I'm respectful that -- that just because a parent might be initially rejecting, it doesn't necessarily mean that -- that repair within that family isn't possible. 12:37:57

Q. BY MR. HILDABRAND: So to make sure I understand your understanding, so in a scenario where a parent does take the time to consider the issue fully but makes a decision and is not physically abusive but tells the child that the parent will not affirm the child's transgender identity, is that child abuse? 12:38:11

MR. SELDIN: Object to form. Calls for a legal conclusion.

THE WITNESS: Yeah. So I don't believe that a parent simply saying "I can't accept that," that that is child abuse. 12:38:27

Q. BY MR. HILDABRAND: Okay. Are you -- so just some quick questions. Are you a surgeon?

A. No. 12:38:48

Q. Are you a neurologist?

A. No.

Q. And are you an endocrinologist?

A. No.

Q. Are you a urologist? 12:38:53

A. No.

Q. Are you a gynecologist?

A. No.

Q. And are you a bioethicist?

A. No. 12:39:00

Q. And you do not personally prescribe puberty blockers or hormones?

A. No.

Q. Sorry. My question was worded poorly, so I just want to be clear. 12:39:10

So it's correct that you do not personally prescribe puberty blockers or hormones?

A. That's correct.

Q. Thank you.

MR. SELDIN: Did you see me flinch? 12:39:21

Q. BY MR. HILDABRAND: I just want to make sure we're clear here, so I don't want to say you said something that you didn't mean.

Puberty blockers are only potentially appropriate for treating gender dysphoria adolescents not gender dysphoric adults, right? 12:39:34

A. Not gender dysphoria adults. Adults typically -- there are occasions when adults have used androgen -- those kind of androgen-blocking drugs, but that's not the norm of -- of care. 12:39:55

Q. Okay. And do you agree that a concern about puberty blockers is that if someone is on puberty blockers for too long, then that might affect bone density?

A. Yes. 12:40:09

Q. What is the longest time period one of your patients has remained on puberty blockers as a treatment for gender dysphoria?

A. I don't have, you know, an actual kind of account of it. But typically, within two years, if they're on puberty blockers, the -- you know, there would be a discussion of moving to hormones if the -- if the youth is continuing to want to pursue transition. 12:40:34

Q. Have any of your patients remained on puberty blockers as a treatment for gender dysphoria for more than five years? 12:40:55

A. Not any -- no. I wouldn't say -- I'd say no. I mean, I think I've had -- I've had some adults who were on antiandrogens alone for a while but not even that long. So I would say no. 12:41:12

Q. Does Tanner Stage 2 normally complete before an individual becomes an adult?

A. Yes.

Q. Have you had patients who are 24 years old and still in Tanner Stage 2 because they took puberty blockers? 12:41:29

A. No.

Q. Okay. I'm going to need you to pull out the Brandt deposition transcript, which is 12:41:40

Exhibit 5, like we were just --

A. Okay.

Q. -- just on that there.

MR. SELDIN: And, Mr. Hildabrand, we're coming up on about an hour. I'm just not sure where you are in terms of -- 12:41:49

MR. HILDABRAND: Yeah. There's a short stream of -- maybe five minutes, and then we take a break. Sound good?

MR. SELDIN: That sounds great. Thank you. 12:41:59

Does that work for you, Dr. Karasic?

THE WITNESS: Yeah.

Q. BY MR. HILDABRAND: And actually, I'm sorry. Let's go to the Brandt trial transcript. I think that's Exhibit 9. 12:42:06

MR. SELDIN: That's the dep. I think you want the trial.

THE WITNESS: Oh.

MR. SELDIN: Right there. 12:42:23

THE WITNESS: Thank you.

Q. BY MR. HILDABRAND: We're going to go to page 282 in this. We're going to look on page 282, lines 5 through 9.

Sir, were you asked the question starting 12:42:57

at line 5, "So was your answer to that, yes, you think someone at Tanner II can make an important decision about that?"

Was that a question you were asked at trial? 12:43:09

A. I assume so.

Q. Did you answer that question, "I mean, I have patients who were Tanner II, and they are 24, because they have been on puberty blockers. I think they're making their own decisions just 12:43:18 fine"?

A. I think that was a transcript error. I would not have said I have patients who are Tanner 2 who are 24.

Q. Have you informed the Court or opposing 12:43:30 counsel in this case that this is a transcript error?

A. No, I haven't. This is the first time I recall actually seeing the transcript of the trial.

MR. SELDIN: Counsel, I want to look back, 12:43:42 because I think the header on this is an Adkins cross, not a Karasic cross.

MR. HILDABRAND: Oh, I'm sorry.

THE WITNESS: Yeah. That would make more sense. 12:43:57

MR. HILDABRAND: There we go. That answered the question right there.

THE WITNESS: I answered truthfully.

MR. HILDABRAND: There we go.

Q. BY MR. HILDABRAND: And so the answer is 12:44:04 no, you do not have any patients who are 24 --

A. No, I do not have any patients who are 24 and Tanner Stage 2.

Q. And you'd find it odd to have a patient who's 24 years old and still Tanner Stage 2; is 12:44:14 that right?

A. It would be very unusual for me because I've never had a patient -- I don't -- I wouldn't see, you know, being on puberty blockers until age 24. 12:44:25

Q. Thank you. And sorry if I messed up. I was not intending to there.

Do you agree that the vast majority of patients who will begin puberty blockers as a treatment of gender dysphoria will start cross-sex 12:44:38 hormones?

MR. SELDIN: Object to form.

THE WITNESS: Can you repeat the question? Sorry. I was just -- I was just thinking about the 24 -- 12:44:46

Q. BY MR. HILDABRAND: I'm glad we clarified that there.

A. Right. I don't remember saying that.

MR. SELDIN: An expert with a typo is like a dog with a bone. You gotta really tell him to 12:44:55 look away.

Q. BY MR. HILDABRAND: Yeah. So do you agree that the vast majority of patients who begin puberty blockers as a treatment for gender dysphoria will start cross-sex hormones? 12:45:05

MR. SELDIN: Object to form.

THE WITNESS: That's correct.

Q. BY MR. HILDABRAND: And do you agree that puberty blockers can be sterilizing if a minor started puberty blockers and then transitions 12:45:14 further with cross-sex hormones?

MR. SELDIN: Object to form.

THE WITNESS: So if they start cross-sex hormones, then it can be sterilizing. Of course, cross-sex hormones for people assigned male at 12:45:28 birth themselves can affect fertility as well.

MR. HILDABRAND: I think you mentioned a break. I think this is a good place to call it --

MR. SELDIN: It's been about an hour.

MR. HILDABRAND: -- so let's go off the 12:45:40

record.

MR. SELDIN: Thank you.

THE VIDEOGRAPHER: We're off the record. The time is 12:45 p.m.

(A recess was taken.) 12:54:31

THE VIDEOGRAPHER: Okay. We're back on the record. The time is 12:54 p.m.

Q. BY MR. HILDABRAND: I guess first of all, did you discuss anything with counsel during the break? 12:54:41

A. No.

Q. And just to close out what I mentioned earlier, does Dr. Adkins practice in North Carolina?

A. I believe she does practice in North 12:54:56 Carolina, yeah.

Q. For cross-sex hormones, do you agree that decreased testicular mass is an irreversible side effect of taking estrogen as a treatment for gender dysphoria? 12:55:12

MR. SELDIN: Objection to form.

THE WITNESS: Yeah, it can be for -- it -- right. It can be an irreversible treatment and that's why for -- when people are starting hormones, if they have -- if they're not already on 12:55:27

puberty blockers -- if it's puberty blockers, it should be before they start puberty blockers. But there should be a discussion about fertility. And the parents and the young person need to be fully aware of potential ramifications on fertility. 12:55:48

Q. BY MR. HILDABRAND: Is decreased testicular mass an irreversible side effect of taking testosterone as a treatment for gender dysphoria?

MR. SELDIN: Object to form. 12:56:01

THE WITNESS: Not for gender dysphoria. There are bodybuilders who take testosterone and have decreased testicular mass that way because of the feedback mechanism, but that's not for gender dysphoria. 12:56:18

Q. BY MR. HILDABRAND: Why is decreased testicular mass an irreversible side effect of taking testosterone as a treatment for gender dysphoria?

MR. SELDIN: Object to form. 12:56:29

THE WITNESS: Because people who are taking testosterone for gender dysphoria typically don't have testes.

Q. BY MR. HILDABRAND: You say "typically."

Are you aware of any individuals with 12:56:43

testes who are prescribed testosterone as a treatment for gender dysphoria?

MR. SELDIN: Object to form.

THE WITNESS: No.

Q. BY MR. HILDABRAND: Let's go to 12:57:00 paragraph 51 in your declaration. This is on page 13. The declaration is Exhibit 1.

A. Sorry. There's a big mound here. Here we go.

Q. All right. And then paragraph 51 on 12:57:25 page 13. This is the section where you discuss the efficacy of puberty blockers and hormone therapy for treating adolescents with gender dysphoria; is that right?

A. Yes. 12:57:58

Q. And you cite "Cornell 'What We Know'" for the benefits of these treatments?

A. I do it to -- I cite it for the statement that "Medical treatment for gender dysphoria has been studied for over half a century." So most of 12:58:17 that half century was -- most that study was on adults.

According to what we know is a compendium of -- it's a systematic review and meta-analysis of treatment of gender dysphoria up until, I think, 12:58:31

1971, but going back -- I'm sorry -- 2017, but going back to the 1970s or '80s, going back many -- many years.

Q. So you'd agree that this "Cornell 'What We Know'" review looks at predominantly studies of 12:58:51 adults?

A. Yes.

Q. And can you name a study demonstrating that medical transition reduces the rate of completed suicides among any population of 12:59:02 transgender minors?

MR. SELDIN: Object to form.

THE WITNESS: So that as a measure, completed suicide, no.

Q. BY MR. HILDABRAND: I see you -- go to 12:59:17 paragraph 59. It's a few pages ahead, page 17. I see you used the word "safe" here to describe gender-affirming medical interventions.

When you use the word "safe" here, do you mean that the benefits of gender-affirming medical 12:59:40 interventions greatly exceed the risk?

MR. SELDIN: Object to form.

THE WITNESS: Yes.

Q. BY MR. HILDABRAND: All right. And when you use the word "safe" to describe these medical 12:59:52

interventions, you don't mean that the interventions are entirely without risk, right?

MR. SELDIN: Object to form.

THE WITNESS: Right. Every intervention has potential side effects. 01:00:04

Q. BY MR. HILDABRAND: Do you agree that there's limited data on the optimal timing of gender-affirming interventions as well as the long-term physical, psychological, and neurodevelopmental outcomes in youth? 01:00:16

MR. SELDIN: Object to form.

THE WITNESS: Can you repeat the question?

Q. BY MR. HILDABRAND: Yeah. So do you agree there's limited data on the optimal timing of gender-affirming interventions as well as the 01:00:25 long-term physical, psychological, and neurodevelopmental outcomes in youth?

MR. SELDIN: Object to form.

THE WITNESS: I think that if we -- it sounds like there's a couple parts to that 01:00:42 question.

So if you're talking about when the optimal time to start, there certainly is some data that in -- for some youth, youth who have -- who have had gender dysphoria at a young age that has 01:01:14

persisted over time, that starting at Tanner Stage 2 can -- can help them. Certainly, the -- the Dutch experience is supportive of that.

But there are people who start gender transition at later times in their life, and 01:01:39 sometimes at what they consider the appropriate time in their life, which sometimes is later in adolescents and sometimes into adulthood.

I have adolescent patients, particularly some nonbinary adolescent patients, who have gender 01:01:58 dysphoria and have considered medical interventions and decided to -- to wait. And so that -- you know, there's not one age for everyone.

In terms of long-term outcomes, there are -- the Dutch are continuing to follow their 01:02:32 population, and, you know, they are -- they have people who are maybe, you know, 30 years from when they started puberty blockers.

But there is the nature of launch to no follow-up with young people in that if you're -- if 01:02:59 you want to know how someone who started on puberty blockers at age 11 is doing at age 80, then it's going to take 70 years to get that -- that research. So, you know, we have research as it kind of comes in. 01:03:19

Q. BY MR. HILDABRAND: Gotcha. And so we don't have research on individuals who started puberty blockers at age 11 as a treatment for gender dysphoria at the age of when they're 50, 60 years old; is that right? 01:03:30

MR. SELDIN: Object to form.

THE WITNESS: Well, the -- the Dutch are following some people who are in their 40s by now. But from that data -- I mean, from their data, we're going to have to wait, you know, for the 01:03:54 systematic study of those folks.

I mean, there have been people, young people, who have been transitioning since the 1950s, if not earlier. And so there are some people who as individuals have transitioned and 01:04:13 lived long lives.

But in terms of a kind of systematic study from the start of puberty blockers to old age, we're going to have to wait.

Q. BY MR. HILDABRAND: Is it your 01:04:32 understanding that the Dutch have been prescribing puberty --

(Clarification by the reporter.)

Q. BY MR. HILDABRAND: Yeah. Had the Dutch been prescribing puberty blockers as a treatment 01:04:44

for gender dysphoria since before 2013?

A. Oh, yeah. Because -- so by the time 2014's DeVries study came around, she was reporting on a population of people who had started on puberty blockers and started on hormones, and then 01:05:07 as adults had surgery, and then following up on those. And so that's quite a number of years from the start of puberty to being adults who've -- who've had surgery.

So they -- the Dutch have had people now 01:05:25 for several decades on puberty blockers, and -- but they had to have, well, 70, I suppose, people who had, you know, made it to adulthood and then had surgery to be able to report for the 2014 paper.

Q. So if the Dutch were prescribing puberty 01:05:54 blockers to a minor in 2010, they would have been using the gender identity disorder diagnosis; is that correct?

MR. SELDIN: Object to form.

THE WITNESS: So in 2010, they would have 01:06:07 been using the gender identity disorder of adults diagnosis.

Q. BY MR. HILDABRAND: Because the gender dysphoria diagnosis did not exist in 2010; is that right? 01:06:19

A. The gender identity diagnosis for children and a separate diagnosis for adolescents and adults did exist back then. And -- but, yeah, they would have in 2010 been using gender identity disorder of adolescents and adults. 01:06:42

Q. But just to be clear to make sure I understand, they would -- in 2010, doctors were not using gender dysphoria in adolescents and adults diagnosis, correct?

A. No. It would have been a gender identity 01:06:59 disorder in 2010.

Q. Let's go to the WPATH standards of care, which I think are Exhibit 7.

(Discussion off the record.)

Q. BY MR. HILDABRAND: We all agree we are on 01:07:50 WPATH's Standards of Care Version 8 right now. Turn to page S65.

Do you see on the -- I'll wait until you get there. Do you see the statement -- it's in the bottom left-hand paragraph -- that "there is, 01:08:16 however, limited data on the optimal timing of gender-affirming interventions as well as the long-term physical, psychological, and neurodevelopmental outcomes in youth"?

A. Yeah. Can you tell me exactly where 01:08:42

you're looking?
Q. Yeah. Page S65 underneath where it says "Considerations of Ages for Gender-Affirming Medical and Surgical Treatment," the paragraph that begins -- 01:08:54
A. Oh, okay.
Q. -- "a growing body." And then it says, "There is, however, limited data on the optimal timing of gender-affirming interventions as well as the long-term physical, psychological, and 01:09:01
neurodevelopmental outcomes in youth."
A. Yes.
Q. And do you agree with this statement?
A. I'm not quite sure what they mean in terms of "limited data on the optimal timing," just 01:09:26
because I view it that the optimal timing is different for different patients. But -- but, you know, I agree that -- certainly that there's limited data on long-term physical, psychological, and neurodevelopmental outcomes to youth. 01:09:48
Q. Okay. And do you agree that the impact of pubertal suppression on brain development is not well known but could be of concern?
MR. SELDIN: Object to form.
THE WITNESS: So I think that it -- when 01:10:08

one says "could be of concern," I think it's something that, you know, is worth continued exploration.
I don't think that there has been any of the papers I have written -- any of the papers that 01:10:24
I've read -- sorry about that -- that clearly show what the, you know, cognitive impact may or may not be.
Q. BY MR. HILDABRAND: So kind of look at the first part of what I asked you there. 01:10:45
Do -- do you agree that the impact of pubertal suppression on brain development is not well known?
MR. SELDIN: Object to form. Asked and answered. 01:10:58
THE WITNESS: So if -- yeah. If that question were asked if there is any neurocognitive impact, whether that's known, I would say no.
I would -- I would say that there are many trans youth that I take care of who have done very 01:11:21
well cognitively and probably better than if they hadn't received care. Because depression and emotional distress can also impair cognitive development.
And so -- so I -- but I do agree that -- 01:11:42

that further research on this would be -- would be useful.
Q. BY MR. HILDABRAND: Did you publish a study in 2017 on vaginoplasties performed on minors? 01:12:01
A. Yes.
Q. And was that a study done with your colleague Milrod?
A. Yes.
Q. And the WPATH Standards of Care Version 7 01:12:13
were the standards in effect at the time of that 2017 paper; is that right?
A. Yes.
Q. And those -- and the WPATH Standards of Care Version 7 did not allow vaginoplasties on 01:12:26
minors, right?
A. Right. They -- their recommended age was -- was 18. But, you know, it was a set of guidelines, and so we did -- we sought out -- even though neither Dr. Milrod or I had had any patients 01:12:49
have vaginoplasties under 18, we surveyed basically all the surgeons that did vaginoplasties with WPATH to find out their -- their experience over the course of their careers, really.
Q. In the study, did you and your colleague 01:13:10

hear that at least one minor received a vaginoplasty at age 15?
A. Yeah. My colleague heard that that was the case.
Q. Did you or your colleague -- I'll say, and 01:13:23
vaginoplasties are quite unusual at age 15; is that right?
A. Yes.
Q. Did you or your colleague report that surgeon to a medical board for further 01:13:35
investigation?
MR. SELDIN: Object to form.
THE WITNESS: No. I don't even know who that surgeon is, because of the -- my colleague collected the data, but it was anonymized, 01:13:53
basically, before -- before I saw it. So I don't know which -- which surgeon that was. It could have, you know, been 20 years earlier for all I know.
Q. BY MR. HILDABRAND: Did your colleague see 01:14:06
the nonanonymized data or conduct the interviews?
A. Yes.
Q. Do you think governments should ever ban treatments?
MR. SELDIN: Object to form. 01:14:20

THE WITNESS: To ban any treatment? So I think that -- that there -- there can be treatments that are happening that -- that are very clearly shown to be harmful without any supported benefit, where -- you know, where that could be a possibility. 01:15:08

My general inclination has been that -- that medical boards should be the primary people looking at, you know, when -- when someone practices outside of the standard of care, outside of kind of community standards. 01:15:31

Q. BY MR. HILDABRAND: So is your standard that government should only step in to ban treatments when a treatment is very clearly harmful and without any supported benefit? 01:15:45

MR. SELDIN: Object to form.

THE WITNESS: Well, that is where I could see that be -- where I could see it be -- you know, where I could see it being justifiable.

Q. BY MR. HILDABRAND: And do you think conversion therapy should be banned? 01:16:08

MR. SELDIN: Object to form.

THE WITNESS: So I've not been someone at the -- at the forefront of conversion therapy bans. But given that there's data showing it to be 01:16:31

harmful and that there have been many decades of data showing it not to be helpful, you know, you could go back to Daniel Brown in 1960, a military psychiatrist who had spent time doing some research at UCLA. 01:16:53

But he published in 1960 that he had never seen a transgender -- or no, that there's no evidence, that no one has ever seen, basically, in the literature as to that time someone change their gender identity with psychotherapy. And he was referring to adults who were being treated at that time. 01:17:10

But -- but, you know, you could go back to that and then -- you know, since then, where there have been surveys showing mental health outcomes in people who have been subjected to conversion therapy. 01:17:30

So I think that that is -- you know, may fall under, you know, that there's clearly no benefit and evidence that it is harmful. But -- but I've -- I've tended to -- my belief has tended to be that -- that those bans are more -- it should be more the province of licensing boards as opposed to things like state criminal penalties. 01:17:51

Q. BY MR. HILDABRAND: Do you agree that 01:18:27

there should not be state civil penalties apart from medical board regulations for conducting conversion therapy?

MR. SELDIN: Object to form.

THE WITNESS: I haven't really thought it through that much, but I do -- I just -- maybe just a little libertarian streak or something, where I do have caution about government overreach, you know, into even, like, the therapy room. 01:18:41

Q. BY MR. HILDABRAND: Is conversion therapy something that healthcare providers can perform for prepubertal minors? 01:19:12

MR. SELDIN: Object to form.

THE WITNESS: Well, no, not according to certainly the law in some places. I do think that some practitioners -- some people who have been accused of conversion therapy in minors have said that what they're doing is not conversion therapy. And so that's, you know, kind of a matter of discussion as to whether -- whether it is or isn't. 01:19:44 01:20:04

Q. BY MR. HILDABRAND: So what do you understand conversion therapy to mean?

A. So conversion therapy is when the therapist is taking a stance upfront that a goal of treatment is to -- to change or keep the person 01:20:22

from being a lesbian or being transgender, and that that -- that is really kind of baked into the -- into the therapy.

Q. Is it your understanding that Dr. Zucker used to encourage prepubescent patients to identify as their birth sex? 01:20:52

MR. SELDIN: Object to form.

THE WITNESS: Yes.

Q. BY MR. HILDABRAND: And do you consider that practice conversion therapy? 01:21:04

A. I have not rushed into -- I was not coming to conclusions that he was a conversion therapist, because I know that was something that he was accused of and that was banned by the Province of Ontario and that he asserted that he was not doing conversion therapy. And, you know, that was -- you know, that controversy does exist. 01:21:33

I -- I would say that there really isn't evidence that his psychotherapeutic intervention to try to realign somebody with their birth sex is effective and there is evidence of harm. 01:22:01

There is a fairly famous case out of UCLA where Lovaas and Rekers did a study. Rekers was the psychology post doc, I believe, who kind of led the effort, and Lovaas was a pioneer in treating 01:22:34

autism at UCLA.
And they had a patient that they reported on as a success of realigning someone with their birth sex. That person came to UCLA as a feminine boy. 01:23:02
He was probably prehomosexual the entire time, had some really abusive treatment encouraged by the therapist by his father, and made a suicide attempt during treatment that was not reported.
They did publish it as a great success. 01:23:22
And later the patient committed suicide -- identified as a gay man, not -- so in that sense, maybe it was a success -- although the people who didn't get therapy in that study identified largely as gay men as well -- committed suicide. 01:23:44
And then the parents sued and brought it to the ABC 20/20 show, so it got a lot of publicity many years after the fact after George Rekers was arrested with a male -- or caught with a male escort. 01:23:59
And it was, you know, shown that this person who was kind of behind this work was -- was somewhat hypocritical with their anti-LGBT views. And I think that publicity brought the family many years after the fact to bring it out into the 01:24:17

public.
But if you look at the publication, that was like -- that was providing that the work that -- that was kind of the intellectual foundation for -- for Ken Zucker's work. 01:24:28
And -- and so clearly you can have harm, and I haven't seen any published evidence of benefit.
Q. All right. So just two quick follow-ups.
So first, you'd agree that it's 01:24:45 inappropriate for a doctor not to publish results that -- simply because they disagreed with whether the results would help the form of treatment that they prefer?
MR. SELDIN: Object to form. 01:25:02
THE WITNESS: Well, now I think we're going to a different subject. But if we're talking about this case, they did publish it. They just kind of lied when they published it. And that led to two young gender-nonconforming people getting 01:25:14 harmful treatment and treatment that, in retrospect in large surveys, have been connected with mental health harm and which never showed benefit.
But, you know, if you're -- if you're referring to a different subject, I'm happy to talk 01:25:34

about that.
Q. BY MR. HILDABRAND: Yeah. So I'd appreciate it. So you'd agree it's inappropriate for a medical researcher to lie about the data that they are publishing, right? 01:25:45
A. Yes.
MR. SELDIN: Object to form.
THE WITNESS: Yes.
Q. BY MR. HILDABRAND: And you agree that it's inappropriate for a medical researcher to 01:25:51 choose not to publish results simply because they do not support a preferred treatment approach of the medical provider?
MR. SELDIN: Object to form.
THE WITNESS: Well, there's a lot of 01:26:06 research that isn't -- isn't published. And there is certainly more research that doesn't find an outcome either way that doesn't get published. So I'm not going to speculate on the motives of every person where that's happened. 01:26:23
Q. BY MR. HILDABRAND: You would not refuse to publish research simply because it does not support your preferred medical treatment practices; is that right?
MR. SELDIN: Object to form. 01:26:35

THE WITNESS: So that's kind of a big hypothetical, but I have, you know, published or been involved in publication of research where, you know, there were some findings that were interesting and there were other kind of hopeful 01:26:50 findings that didn't materialize. This is not in the gender world. This has to do with depression treatment.
So, you know -- but the -- what I can say about being in -- particularly about my experience 01:27:09 doing randomized clinical trials with depression treatment is that there are a lot of variables that can come into play that are unexpected.
Even with randomization, you don't always end up with two equal groups, and that sometimes 01:27:29 you don't get the kind of clarity of information that you're -- you're seeking.
I don't think I can talk, though, about all hypotheticals. I'm talking about my experience. 01:27:50
Q. BY MR. HILDABRAND: Yeah. So before you go down that, just to clarify an earlier line of questioning, I was asking you about Dr. Zucker.
Do you mind just explaining -- since I think we both have some understanding of who he is, 01:28:00

but do you mind just explaining just very briefly who Dr. Zucker is?

A. Sure.

MR. SELDIN: Object to form.

THE WITNESS: So Dr. Zucker is a psychologist who for many years was at University of Toronto, and his clinic along with the adult clinic at University of Toronto were the kind of sole assessors from the province of Ontario for -- for his clinic's transgender youth and for the adult clinic for adults. And so he -- he had that role for many years. 01:28:07 01:28:33

And then after a -- after the province of Ontario passed an anti-conversion therapy law, he was accused of conversion therapy. And even though there was not a finding that he was practicing conversion therapy, they decided to close his clinic anyway. 01:29:02

Q. BY MR. HILDABRAND: And did Dr. Zucker -- was he a coauthor of the WPATH Standards of Care Version 7? 01:29:20

A. Yes.

Q. He was not an author of the WPATH Standards of Care Version 8?

A. Yes. 01:29:31

Q. Have you seen -- there's an article in the New York Times this past week about Dr. Olson-Kennedy.

Did you see that article?

A. I did see that article. 01:29:45

Q. Would it be appropriate for Dr. Olson-Kennedy to refuse to publish data about the effects of puberty blockers solely because the data would not support prescribing puberty blockers as a treatment for gender dysphoria? 01:30:03

MR. SELDIN: Object to form.

THE WITNESS: So I was a little -- I was a little puzzled by the article just because that group has published a bunch, and they've also presented their data regularly, including the WPATH conference in Lisbon and in Montreal. 01:30:13

I don't know about the framing of the article, and so I'm hesitant, having not talked with Dr. Olson-Kennedy, to really, you know, pass judgment in some way. 01:30:35

But I -- also, I didn't read it as that she was refusing to publish it but that they -- you know, that this was -- that certainly that they were, you know, concerned about the current 01:31:01

political climate that the -- the article might come out in. But again, that was just my take reading --

Q. BY MR. HILDABRAND: Gotcha.

A. -- reading the article. 01:31:17

Q. We can ask Dr. Olson-Kennedy someday.

A. Yeah. Exactly. You'll have the opportunity to get that much more directly than me.

Q. Let's turn back, then, to what you wrote. Let's go to paragraph 59 in your declaration. This is on page 17, paragraph 59. 01:31:27

You write that "Gender-affirming medical interventions in accordance with the WPATH SOC 8 and Endocrine Society Guideline are widely recognized in the medical community as safe, effective, and medically necessary for many adolescents with gender dysphoria," right? 01:31:50

A. Yes.

Q. And your first citation here is to the American Academy of Pediatrics, 2018, right? 01:32:02

A. Yes.

Q. And to be clear, the American Academy of Pediatrics has not endorsed WPATH Standards of Care Version 8?

MR. SELDIN: Object to form. 01:32:14

THE WITNESS: No. I don't know what they may have said in any amicus briefs or otherwise. But actually, some of these citations -- maybe it would be more accurate to say gender-affirming medical interventions in accordance with WPATH standards of care, because, of course, the 2018 citation was when Standards of Care 7 was -- was in effect. 01:32:36

And -- and so -- but I'm not -- I wasn't talking about necessarily a formal endorsement by the organizations. Some of the organizations have recognized standards of care in documents like amicus briefs. 01:32:55

But also in the publications of the different organizations, they've made reference to the standards of care and Endocrine Society guidelines in terms of recommendations and practice guidelines. 01:33:17

Q. BY MR. HILDABRAND: And just to be clear, all of the citations you provided here other than WPATH 2022 predate the publication of WPATH Standards of Care Version 8? 01:33:32

A. Right. And so in that case, it really should have just been WPATH standards of care and not W -- and not SOC8. I think that's an error in 01:33:46

that -- in that statement.
Q. Gotcha. And the American Academy of Pediatrics has not formally endorsed the WPATH Standards of Care Version 8, right?
MR. SELDIN: Objection to form. 01:34:04
THE WITNESS: It would be unusual to have a formal endorsement. But many -- many organizations have referenced the WPATH standards of care, as I said, in amicus briefs and also in their own clinical guidelines as it relates to the 01:34:26 care of transgender people.
Q. BY MR. HILDABRAND: But am I correct that you don't cite any formal endorsement by the American Academy of Pediatrics --
A. Right. 01:34:39
Q. -- of WPATH Standards of Care Version 8?
A. Yes.
Q. And am I correct that you do not cite any formal endorsements of the WPATH Standards of Care Version 8 by the American Medical Association? 01:34:48
A. Yes.
Q. So shortly after the publication of WPATH Standards of Care Version 8, you testified at trial in the Brandt case in Arkansas; is that right?
A. Yes. So let's see. The Brandt case, it 01:35:06

looks like the testimony was October 17th, 2022, and Standards of Care 8 -- just trying to think of what the date was, but it was -- they were close.
Q. They were close. Let's look at the transcript there. So let's look at the transcript 01:35:28 from the trial. I think that was Exhibit 9.
Do you see on the first page it says October 17, 2022?
A. Yes.
Q. So that would have been right after -- 01:35:54
A. Right after, yes.
Q. Sorry. Just to be clear, October 17, 2022, would have been slightly after the publication of the WPATH Standards of Care Version 8? 01:36:10
A. Yes.
Q. All right. Just making sure this is what you testified to here.
So let's go to page 34 and, actually, the last line on page 33. Your answer to a question 01:36:39 was that "I would say especially the WPATH Standards of Care." Because we're talking about the WPATH standards of care here.
And the question you were asked at 2 to 3 was, "Are they recognized as best practices by any 01:36:55

professional groups," right?
A. Yes.
Q. And your answer to that question was, "Yes. Many large mainstream medical and mental health organizations recognize the WPATH Standards 01:37:05 of Care in different ways as an authority and practice guidelines for transgender health."
Is that your testimony?
A. Yes. Yes.
Q. And then you're asked the question, "Could 01:37:17 you name some of those organizations?"
And your answer was, "Sure. The American Psychiatric Association that I'm part of, the American Psychological Association, American Medical Association, the American Academy of 01:37:29 Pediatrics are some of the many organizations that recognize the WPATH Standards of Care."
Is that what you testified?
A. Yes.
Q. When you say "recognized" here, you do not 01:37:39 mean formally endorse; is that correct?
A. Yes.
Q. With your declaration in this case, did you include an Exhibit B, bibliography? And feel free to look at it. This is Exhibit 1. 01:38:20

MR. SELDIN: Right here.
THE WITNESS: Yes.
Q. BY MR. HILDABRAND: If you want to turn to it. It's around docket page 44 in here.
A. Yes. 01:38:42
Q. So this bibliography includes, among other sources, some letters and position statements by organizations mentioned in your declaration; is that right?
A. Yes. 01:38:50
Q. Not all of the documents in Exhibit B were peer-reviewed publications, right?
A. Meaning the -- well, I mean, the articles were peer reviewed, but some of the policy statements could just have been, you know, the 01:39:07 policy statements of the organization.
Q. Right. So is one example the American Medical Association's 2012 letter to the National Governor's Association, that was not a peer-reviewed publication, right? 01:39:22
A. Right. But my understanding is at least from the workings of the American Psychiatric Association, that when they do put forward a position of public statement, that it is consistent with their -- the -- what's previously been 01:39:41

approved by the organization.
Q. And another one I just wanted to ask about is the Williams Institute 2022 publication.
A. So -- I'm sorry. Where's that?
Q. Well, I think you reference somewhere. 01:40:18
I'm sure we'll see it here.
A. You mean Herman?
Q. Yes. There we go. Thank you.
Was that a peer-reviewed publication?
A. I don't recall. That may well just be a 01:40:36
self-publication of their own survey. But I don't know if they've published it in any form.
Q. It looks like it was published at the williamsinstitute.law.ucla.edu website.
A. Okay. 01:40:55
Q. Is that right?
A. Yeah. Looks like it, yes.
Q. Was there also -- did WPATH also publish a medical necessity statement in 2016?
A. Yes. 01:41:18
Q. Was that a peer-reviewed publication?
A. No.
Q. Was that simply constituting the professional and clinical opinions of the signers?
MR. SELDIN: Object to form. 01:41:28

THE WITNESS: Yes, yes.
Q. BY MR. HILDABRAND: And you're one of the authors of the 2016?
A. Yes. It was a product of the board of directors at the time, and I was on the board. 01:41:37
MR. HILDABRAND: I'll give you a copy of that right here. I'll enter that as -- I think we're on Exhibit 12. Enter this as Exhibit 12.
(Reporter marked Exhibit Number 12 for identification.) 01:42:15
Q. BY MR. HILDABRAND: Is this an accurate copy of the 2016 "Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A."?
A. Yes. 01:42:26
Q. Let's turn toward the end of the document, so the last page before you get the list of signers here.
Do you see where it says, "Professional associations that have issued statements in support 01:42:47
of the WPATH standards of care include," and then it has a list of medical organizations there?
A. Yes.
Q. And is the second-to-the-last organization mentioned the American Society of Plastic Surgeons? 01:43:01

A. Yes.
Q. What is the American Society of Plastic Surgeons?
A. They are a professional organization of American plastic surgeons. 01:43:15
Q. Am I correct that you do not mention the American Society of Plastic Surgeons in your declaration as a group that has supported the WPATH Standards of Care Version 8?
A. No, I did not. 01:43:30
Q. Am I correct that you don't mention the American Society of Plastic Surgeons anywhere in your declaration; is that right?
A. No.
Q. And just for clarity -- and I see you 01:43:46
smiling there -- you did not mention the American Society of Plastic Surgeons in your declaration.
Is it correct that you did not mention the American Society of Plastic Surgeons in your declaration? 01:44:03
A. Yes, it is correct.
Q. Okay. Thank you.
MR. HILDABRAND: I will enter this, as I think we are on Exhibit 13. And one more.
(Reporter marked Exhibit Number 13 01:44:16

for identification.)
Q. BY MR. HILDABRAND: Have you seen this document before?
A. Yes.
Q. Is this a statement that the American 01:44:45
Society of Plastic Surgeons published on August 14th, 2024?
A. Yes.
Q. So this statement was published a week before you signed your declaration, correct? 01:44:57
A. If that was -- was that August 20 -- I'd have to --
Q. Feel free to refer to your declaration if you want.
(Discussion off the record.) 01:45:08
THE WITNESS: Yeah. It was one week before, yes.
Q. BY MR. HILDABRAND: Are you aware that the American Society of Plastic Surgeons has not endorsed any organization's practiced 01:46:02
recommendations for the treatment of adolescents with gender dysphoria?
A. That's what they said, yes.
Q. And the American Society of Plastic Surgeons currently understands that there's 01:46:17

"considerable uncertainty as to the long-term efficacy for the use of chest and genital surgical interventions for the treatment of adolescents with gender dysphoria"; is that correct?
A. That's what they state. I mean, certainly, you know, as we talked about, they're not doing genital surgical interventions on adolescents. It really comes down to chest surgery for transmasculine youth, where I would disagree in terms of uncertainty about even long-term efficacy, you know. 01:46:33 01:46:53
It was Bruce, et al., that -- where they looked at thirty-year experience chest surgery. The median age was young adults, but where there was very high satisfaction over that 30 years of experience. 01:47:23
And so -- so, you know, it's -- I don't think there's an absence of -- you know, of data. But I do agree that there is an absence of data on genital surgical interventions, because those are not done -- typically done. 01:47:44
Q. All right. And you agree that a vaginoplasty is a genital surgical intervention?
A. Yes.
Q. And as shown with your 2017 article, some 01:47:57

surgeons in the United States have performed vaginoplasties on minors as a treatment for gender dysphoria?
A. I think a handful have. I'm not aware of surgeons who are currently doing that, just because I have minor patients who have reached out to the offices of quite a number of surgeons, asking if they have a minimum age of 18. And the response they've heard back is yes. And so -- and none of my patients have -- have received treatment for that. 01:48:14 01:48:35
But our study did find that there were some surgeons who had reported at some point having done surgery on people under 18.
Q. But you agree that the current standards of the United States is not to perform vaginoplasties on minors as a treatment for gender dysphoria? 01:48:50
MR. SELDIN: Object to form.
THE WITNESS: I would agree that -- that that is standard practice. You know, one could make the argument, as some surgeons did in the 2017 paper, that someone who is very -- very mature -- very mature and transitioned a long time ago and they're 17 and going away to college and the family 01:49:04 01:49:30

wants them to have surgery before starting in the dorms as a freshman, that one could come up with scenarios, which I think were probably the majority of the times that that was done in the past.
But it hasn't come up in my -- in my practice. And even in that scenario, there have been decisions that -- for example, that the patient might have surgery scheduled for the summer after the first year of school. 01:49:53
Q. BY MR. HILDABRAND: And just one last question about this. 01:50:12
The ASPS currently understands that the existing evidence base for chest and genital surgical interventions for the treatment of adolescents with gender dysphoria is low quality/low certainty; is that correct? 01:50:24
MR. SELDIN: Object to form.
THE WITNESS: Well, that was the statement that they -- that they released.
Q. BY MR. HILDABRAND: WPATH's membership includes some lawyers as voting members; is that correct? 01:50:40
A. Yes. There are a handful of -- of lawyers or legal scholars who are in WPATH.
Q. And you were the chair of the mental 01:50:55

health chapter for WPATH's Standards of Care Version 8, right?
A. Yes.
Q. You cannot speak to whether the people involved in drafting WPATH Standards of Care Version 8 outside of your chapter were experts? 01:51:04
MR. SELDIN: Object to form.
THE WITNESS: So I can't speak to -- to every member of Standards of Care 8, only those in my chapter. But the process to join a chapter was really meant to try to find the experts in the field. 01:51:20
However, each chapter also had a representative appointed in addition to that process, that -- a kind of community representative of sorts. But in our chapter, that person was a psychotherapist and certainly very valuable. Even though they weren't an academician in transgender care, they provided valuable perspective. 01:51:44
Q. BY MR. HILDABRAND: And you do not know how the other chapter committees selected the studies they cited in their chapters; is that correct? 01:52:12
MR. SELDIN: Object to form.
THE WITNESS: That's correct. Each 01:52:23

chapter worked independently. We saw the Delphi statements, and then we didn't see the chapter as a whole until it was released publicly.

Q. BY MR. HILDABRAND: And so your experience with the WPATH Standards of Care Version 8 was really contained to the chapter that you were the chapter lead on and voting -- in voting for Delphi statements; is that correct? 01:52:34

MR. SELDIN: Object to form.

THE WITNESS: Yes. 01:52:44

MR. SELDIN: And, Mr. Hildabrand, it's been about an hour, but I am not sure where you are in this line.

MR. HILDABRAND: I think it is a great place to stop. Let's go off the record. 01:52:51

THE VIDEOGRAPHER: We're off the record. The time is 1:52 p.m.

(A recess was taken.)

THE VIDEOGRAPHER: We're now on the record. The time is 2:01 p.m. 02:02:17

Q. BY MR. HILDABRAND: Did you discuss anything with counsel during the break?

A. No.

Q. Great.

MR. HILDABRAND: I am going to introduce 02:02:30

Exhibit 14.

(Reporter marked Exhibit Number 14 for identification.)

Q. BY MR. HILDABRAND: Did you create a supplemental declaration in the Voe v. Mansfield case? 02:02:57

A. Yes.

Q. Is this a -- the public version of that supplemental declaration?

A. Yes. 02:03:05

Q. And if you turn to page 14 of the declaration, did you declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct?

A. Yes. 02:03:27

Q. Let's turn to pages 3 and 4. When you get there, do you see paragraph 10?

A. Paragraph 10 on page 3?

Q. Yes.

A. Yes. 02:03:56

Q. And it also goes on to page 4, right?

A. Yes.

Q. Does paragraph 10 accurately reflect the timeline for the development of the WPATH Standards of Care Version 8? 02:04:15

A. Yes.

Q. And stakeholders provided feedback on the publicly-released draft of the WPATH Standards of Care Version 8 from November 2021 to January 2022, correct? 02:04:26

A. Yes.

Q. And WPATH Standards of Care Version 8 was finalized by the chair and cochairs on June 10th, 2022, correct?

A. Yes. 02:04:37

Q. And there were no major edits to the WPATH Standards of Care Version 8 after it was finalized by the chair and cochairs on June 10th, 2022, correct?

A. Well, I didn't see it from the time of 02:04:50 the -- from the -- I didn't see it in its entirely -- entirety from the release of its public -- the public release of this draft until its publication. So I can't -- I can't say when revisions after public comment actually happened. 02:05:21

Q. You were -- you were the chair of the chapter on mental health, right?

A. Yes.

Q. So did you review the June 10th -- sorry. Did you review the version of the WPATH 02:05:37

Standards of Care Version 8 that was finalized on June 10, 2022?

A. I only reviewed the final draft of my chapter. So, you know, we know of that timeline from the timeline provided by the editors. But for 02:05:57 most of the process, each chapter chair worked on their -- on their chapter.

And -- and so in terms of the June 10th, I -- I'm not sure of the exact date. But in that -- in that time period, you know, I had -- 02:06:21 actually, probably before that, I had word that our chapter had been approved in its -- in its final draft.

Q. So you did not see -- outside of your chapter, you did not see the version of the WPATH 02:06:37 Standards of Care Version 8 that was finalized on June 10th, 2022, right?

A. That's correct.

Q. And your chapter was the mental health chapter. That was Chapter 18, right? 02:06:56

A. Yes.

Q. Did you edit any other chapters?

A. No.

Q. Did you draft a medical necessity statement that went into Chapter 2 on global 02:07:10

applicability?
A. I provided input into a medical necessity statement. I -- I was asked to provide and put on that, given my experience as a board member. And as a board member, we -- we had approved that 02:07:33
previous statement on medical necessity and also had a discussion that -- that a new version of it should be in Standards of Care 8.
Q. Did you provide any edits for the medical necessity statement for WPATH Standards of Care 02:07:52
Version 8?
A. Yes. I -- I provided my input into it. I don't recall all of the input, but -- but I did provide input into the medical necessity statement in -- in standards of care, which was not in my -- 02:08:10
in my chapter.
Q. What do you mean by "input," just so I understand what you mean here?
A. I don't remember the details, but I think I was asked by Eli Coleman who was involved along 02:08:28
with the global applicability chapter that that section was in in terms of -- in terms of having that -- that portion in that chapter. And so I was asked for input, and I provided input.
Q. And -- sorry. What -- what do you mean by 02:08:54

"input"? Do you mean comments? Do you mean edits? Did you draft the medical necessity statement? What -- what sort of input do you mean?
MR. SELDIN: Object to form.
THE WITNESS: So my recollection is that I 02:09:07
made comments on the draft.
MR. HILDABRAND: Okay. I'm going to introduce another document here, Exhibit 15.
(Reporter marked Exhibit Number 15 for identification.) 02:10:04
Q. BY MR. HILDABRAND: Does this appear to be a summary judgment exhibit filed in the Boe Alabama case?
A. Yes.
Q. And if you want to turn to -- I think it's 02:10:20
marked as BOEAL_WPATH_126713. I'll provide you the page number of the document.
A. I'm sorry. 1267?
Q. 13.
A. 13. Okay. 02:10:46
Q. It's going to be marked at the bottom here as 75. And feel free to refer to the previous page or the next page if you need to.
But was this an email circulated among WPATH members about the medical necessity 02:11:11

statement?
A. This seems like a comment by one of the people who is commenting on -- on it.
MR. SELDIN: And I'll just note for the record, Counsel, that this exhibit contains 02:11:52
redactions, I assume, that are original redactions from the filing?
MR. HILDABRAND: This is the -- this is the redactions from the version that was filed on the docket on October 9th, 2024. 02:12:02
MR. SELDIN: Thank you.
Q. BY MR. HILDABRAND: Do you see in this January 6, 2022, email where it says, "Thank you for putting this together. You've done a great job with this. Indeed, it is important that such a 02:12:18
statement is part of the actual SOC"?
A. Yes.
Q. Was the 2016 statement not a part of the Standards of Care Version 7 itself?
A. That's correct. There was mention, brief 02:12:32
mention, of medical necessity in Standards of Care 7. It was at a time, I think, where there -- there was less of an issue because there was less insurance coverage in the U.S. as it was being put together in that time period of 2009 to 2011. 02:12:53

And -- and so the board put out a statement in 2016 about medical necessity. And then at that time, the board discussion was that in the future that this should just be updated with each standards of care. 02:13:32
Q. And does the email go on to say that "indeed, the original medical necessity statement was specific to the U.S. because this is where we were experiencing the problem with our obtuse and unhealthy system of healthcare coverage, and we 02:13:43
need a tool for our attorneys to use in defending access to care here"?
A. That's what that comment says.
Q. Was the original medical necessity statement a tool for attorneys to use in defending 02:13:56
access to care in the United States?
A. No. You know, I -- I don't know who wrote this comment. But it was not so much -- in my experience, it was not so much attorneys, but it was with -- for example, independent medical 02:14:18
reviews, they did want to know WPATH's views on the medical necessity of individual procedures. And so having some specificity about that, I think, was -- was part of that in terms of my experience.
But the legal issues over medical 02:14:56

necessity didn't really start happening, at least my experience, until 2020, 2021 or so when the kind of political battles over transgender care started.

Q. So is the more recent medical necessity statement, was that designed as a tool for attorneys to use in defending gender-affirming care? 02:15:22

MR. SELDIN: Object to form.

THE WITNESS: No. I mean, not in -- in my view, it was -- you know, there was a decision in 2016, which was long before these legal actions, to have -- try to have a medical necessity statement. And there was a decision at that time in the board that we should be updating it with -- with the standards of care. 02:15:37 02:16:07

And -- but that -- all of that discussion -- and certainly, you know, there -- there was -- there were questions of what procedures might be medically necessary, what might not. But there wasn't the -- this kind of political debate until much later. 02:16:22

And -- and we had already -- had made the decision even back in 2016 that this should be included in the standards of care. And it was part of the discussion that we had when we had meetings. 02:16:48

We had meetings around standards of care at the WPATH meeting in Buenos Aires in 2018. And this was, you know, part of discussions that I recall back then. And so while it could be, you know -- certainly WPATH standards of care is being used in legal contexts that we wouldn't have anticipated when we started doing first Standards of Care 7 and then Standards of Care 8. 02:17:18

But it -- we didn't do the standards of care -- our audience wasn't politicians. It was to be putting out a practice guideline for -- for clinicians, really. 02:17:36

Q. BY MR. HILDABRAND: When were you first hired as an expert witness to work on a case where plaintiffs have challenged a -- the law regarding gender-affirmative care? 02:17:50

MR. SELDIN: Object to form.

THE WITNESS: It would have been in 2020 or 2021.

Q. BY MR. HILDABRAND: So is it fair to say that you were hired as an expert witness to testify on behalf of plaintiffs challenging laws regarding gender-affirming care before the publication of WPATH Standards of Care Version 8? 02:18:03

MR. SELDIN: Object to form. 02:18:15

THE WITNESS: Yes. Yes.

Q. BY MR. HILDABRAND: And let's go to -- it's going to be page 70 in this document here.

It's marked at the bottom as BOEAL -- BOEAL_WPATH_126708. 02:18:27

Is this an email sent on April 29, 2022, that you were a recipient on?

A. Yes.

Q. And the medical necessity statement had passed the Delphi process by April 29, 2022; is that correct? 02:18:57

A. Yes. That's what it says.

Q. All right. Let's go to page 69 now. It is right next door.

So after the medical necessity statement completed the Delphi process, a WPATH author asked to remove the word "wishing" because "wishing" makes the medical care seem optional, correct? 02:19:26

MR. SELDIN: Object to form.

THE WITNESS: I see that, you know, in the -- in this email that was sent out. I can -- I see somebody made that comment. 02:19:50

Q. BY MR. HILDABRAND: And you received that email, right?

A. Yeah. I assume I did, because I can see 02:20:03

that my name is not redacted, that I was on the email list of people involved in the editing of the medical necessity statement.

Q. Do you see where the individual who sent the email asked, "Would it be possible or advisable or prudent to replace 'wishing' with 'in need of' here"? 02:20:16

A. Yes.

Q. Do you know if that change was made to the medical necessity statement WPATH Standards of Care Version 8? 02:20:29

A. I don't -- I do not know.

Q. Let's turn to --

A. I would tell you in, you know, chain emails about editing, not this, but, you know, papers I've been involved in, that very often it seems like somebody would pick out a word and say, "I don't like this word. Can we use a different word?" 02:20:41

Q. All right. Let's turn to pages 65 to 66. They're marked BOEAL_WPATH_126704 and then -- I'm sorry -- 703 and then 704. 02:20:52

A. Yes.

Q. Is this an email that you sent in May 2022? 02:21:14

A. This -- we're looking on page 65. We're looking at a -- an email sent by somebody else that quotes me. Says, "Good morning, Dan and everyone."
So somebody was responding, I think, to something that I had -- that I had written. 02:21:37
Q. Yes. So I see the email up at the top that says, "Dan, you write." Then do you see at the bottom of page 65 where it says "from: Dan Karasic"?
A. Wait. Where are you talking about? Oh, 02:21:50
there. Oh, so you're talking about the -- at the bottom of 65? Okay.
Q. Sorry. There's multiple emails and just clarifying.
A. Yes. 02:22:00
Q. I am talking about the one here that you sent.
A. Yes.
Q. So you sent this email starting at the bottom of page 65 -- 02:22:06
A. Yes.
Q. -- and going to the top of page 66?
A. Let me look on page 66. Yes.
Q. And you explained in your email that establishing medical necessity is central to all 02:22:16

healthcare provision in the U.S.?
A. Yes.
Q. And you also explained that "currently, there are lawsuits in the U.S. trying to reverse the position of trans healthcare by asserting that 02:22:29
it is categorically not medically necessary"?
A. Yes. So this was in -- I think in this email conversation with the -- the broader chapter lead that included the medical necessity statement who was from another country, where perhaps medical 02:22:49
necessity was not part of their -- was not used in the same way. So that was -- that was why that discussion happened.
Q. And you also said that "the policy of the U.S. Federal Government from 1981 to 2014 was that 02:23:08
trans care was experimental, not medically necessary, which meant that insurance and government provision of healthcare was allowed to exclude trans care during those years."
Is that part of what you said here? 02:23:25
A. That is correct.
Q. And it is correct that the policy of the U.S. Federal Government from 1981 to 2014 was that trans care was experimental?
A. Of the U.S. -- 02:23:36

MR. SELDIN: Object to form.
You can answer.
THE WITNESS: The U.S. Federal Government said in 1981 that transgender care was experimental and, thus, did not need to be covered and wasn't 02:23:50
covered by Medicare.
Q. BY MR. HILDABRAND: And --
A. And then that did not -- it reversed until 2014.
Q. And just to be clear, when you say "trans 02:24:06
care," are we talking about gender-affirming care?
A. Yeah. We're talking about medical care related to transition.
Q. And then you go on at the very end of this paragraph to say that "the right wing in the U.S. 02:24:26
is trying to force us back to those years or worse."
A. Yes.
Q. And is that what you believed, that "the right wing in the U.S. is trying to force us back 02:24:34
to those years or worse"?
MR. SELDIN: Object to form.
THE WITNESS: So I'm not a political activist, but that was my read on what was happening in 2022 and, you know, continues to be 02:24:54

happening, is that transgender care has become politicized in a way that is not beneficial to our patients.
It's become a political talking point, a way for people to try to win elections. And -- and 02:25:16
I don't think that is a measured way to determine the care that we provide.
Q. BY MR. HILDABRAND: And so this first paragraph that you had here starting with "Thanks, this document is an update," and going to "force us 02:25:36
back to those years or worse," that was your explanation for why the medical necessity statement had utility in the United States, correct?
MR. SELDIN: Object to form.
THE WITNESS: No. So the medical -- 02:25:49
the -- I was commenting to somebody from another part of the world of why people might be passionate about this in the United States, yet it seems inapplicable in some other parts of the world. There -- there is a different environment that 02:26:19
we're in.
But the decision to have the medical necessity statement focused on insurance reimbursement in the U.S. was made by the board. And I mentioned that in a previous email in the 02:26:33

email chain that we had seen.
There was a decision in 2016, not only to put out the -- the medical necessity statement, but that it should be updated with -- with the standards of care. 02:26:53
So this person was either working on the global applicability chapter and I think wondering why is there this globally applicable when this seems kind of America centric. And that was, I think, part of my conversation about why they might 02:27:10
be seeing some passion about this among the American members who are commenting, because this has become a politicized issue.
But -- but having the medical necessity statement in -- in the standards of care was 02:27:26
something that was decided long before any of these court cases happened.
Q. BY MR. HILDABRAND: Gotcha. So then you went on to say, "So this statement is incredibly important in the U.S. but might not have utility 02:27:40
everywhere in the world and is useful for the statement to have global applicability, but this is a case in which a U.S.-centric statement is defensible."
A. Yes. 02:27:51

Q. And so is this your explanation here for why this U.S.-centric statement is defensible?
A. Yes.
Q. Let's go to page 64. It's marked at the bottom as BOEAL_WPATH_126702. 02:28:05
Is -- in the middle of the page, is this another May 2022 email that you've sent?
A. Yes.
Q. Did you note in this email that "medical necessity is at the center of dozens of lawsuits in 02:28:30
the U.S. right now"?
A. Yes, I did say that.
Q. And you also stated that it is "as well as being at the center of all reimbursement for trans care in the U.S.," right? 02:28:52
A. Yes.
Q. Let's go to page 43.
A. Page 43, you say?
Q. 43. It's marked at the bottom as BOEAL_WPATH_109286. 02:29:23
So is this an August 27, 2021, email that you sent before the medical necessity statement went through the Delphi process?
A. Yes.
Q. And did you state that "there are 02:29:45

important lawsuits happening right now in the U.S., one or more of which could go to the Supreme Court on whether trans care is medically necessary versus experimental or cosmetic"?
A. Yes. 02:30:08
Q. And then did you say, "I cannot overstate the importance of SOC8 getting this right at this important time"?
A. Yes.
Q. So this is an important time because there 02:30:20
are important lawsuits happening in the U.S., and there is now a case in the U.S. Supreme Court involving gender-affirming care; is that right?
MR. SELDIN: Object to the form.
THE WITNESS: Well, at that time there 02:30:32
wasn't a case at the -- at the Supreme Court.
But in this comment, I mean, I also do say, you know, this was a very long plan. But then when there was some discussion -- and I don't know if it's included in here -- of -- again, this was 02:30:52
kind of a back-and-forth with someone from another part of the world who was saying -- you know, similarly when I talked about the discussions of using gender incongruence rather than gender dysphoria, there was a strong sentiment from people 02:31:09

outside the United States that the document have global applicability. And indeed, there's this global applicability chapter.
And I was trying to make the argument that, well, the United States is part of the world. 02:31:24
And so, you know, even if certain parts of the standards of care are more central to the United States, they're still important.
But the -- the decision to put it in was actually made -- and which I mentioned somewhere in 02:31:41
this string too -- by the board back -- way back in 2016. And the -- the 2016 statement was pretty expansive too in terms of the care that's provided.
And I did want that -- just a kind of a statement that is -- that's very clear and -- but 02:32:07
the -- there have been this very long previous discussion about -- about its inclusion.
And so the decision for its inclusion was not made in response to the fact that there were lawsuits. 02:32:34
My comments of somebody asking why is this important, you know, was -- well, just, you know, in the United States, we are more focused on this than we have been.
Q. BY MR. HILDABRAND: When was the first 02:32:49

draft of the medical necessity statement for WPATH Standards of Care Version 8 created?
MR. SELDIN: Object to form.
THE WITNESS: So while the original draft was in 2016, and so that was the -- you know, the medical necessity statement. And so that was the starting point for putting out a statement in -- in Standards of Care 8. 02:33:01
Q. BY MR. HILDABRAND: And the 2016 statement was the one that was published shortly after with -- separately from WPATH Standards of Care Version 7, right? 02:33:15
A. Yes.
Q. And when was the decision made to put the medical necessity statement in Chapter 2 on general applicability? 02:33:26
A. So that was an editor's decision that I didn't have anything to do with.
There was -- you know, the decision that I was involved in was in 2016. I was not the author of -- I remember I was one of the coauthors. I was a member of the board. But I was not the primary author of the original medical necessity statement. But I was on the board, and we approved that we were the authors as the people who approved the 02:33:44 02:34:02

statement.
And when we did that, we also decided that the appropriate time to update this statement would be on future iterations of the standards of care.
Q. Has expanding health insurance coverage for gender transition surgeries -- 02:34:18
(Reporter clarification.)
Q. BY MR. HILDABRAND: Has expanding health insurance coverage for gender transition surgeries made those surgeries more common? 02:34:32
MR. SELDIN: Object to form.
THE WITNESS: Has -- you mean expanding insurance access?
Q. BY MR. HILDABRAND: Yeah. Has expanding health insurance coverage for gender transition surgeries made the surgeries more common? 02:34:47
A. So there are people who -- who get the surgeries who never were able to.
For example, I know in San Francisco when there was the expansion, there was a decision by the State of California that Medi-Cal, California's Medicaid, should include transgender surgeries, and at the same time there was the expansion of the Affordable Care Act, that we had quite a number of people in San Francisco who couldn't afford surgery 02:35:07 02:35:27

until they had coverage.
So when they had coverage -- some people have waited 20 years for surgery and -- and then had it once there was coverage.
Q. All right. Can you go to the Brandt trial transcript. This was marked as Exhibit 9. Let's go to page 190 in here. 02:36:03
Do you see your answer?
It says question at line 10, "In the course of writing" this "article" -- or "In the course of writing the article, you learned that there was an increase in the number of minors being referred for vaginoplasty, correct?" 02:36:49
Were you asked that question?
A. Yes. 02:37:00
Q. And was your answer that "at that time, it was 2016. And in 2013 and 2014 is when insurance started covering vaginoplasty more generally in the US. And so it was a time where there was an increase because more people could afford to get it and there were new surgeons who were entering practice at that time. And so -- so it was a time, whether people were minors or not, where more people were getting -- had access to vaginoplasty." 02:37:13
A. Yeah -- 02:37:24

Q. Is that what you testified?
A. So I made a little bit of an error there. Because in my response I was talking about vaginoplasty more generally, not that there was -- that had an idea of -- because insurance coverage, I think, you know, may well not have been covering those, you know, any other vaginoplasties in minors. 02:37:41
So when I was talking about 2013 and 2014, I was talking about vaginoplasty more generally in the U.S. And so more -- so more -- more vaginoplasties were -- were taking place. 02:38:03
The numbers over time with -- for minors I think is -- I think it was very small then, and I think it's less now. But in my mind, that answer was about -- was that there were people who started getting surgery they couldn't afford once they had insurance coverage. 02:38:37
Q. Is it your understanding there are more vaginoplasties being performed on adults today than there were in 2013? 02:38:54
A. Yes.
Q. And are there more vaginoplasties being performed on adults in today's gender-affirming treatment than there were in 2016? 02:39:06

A. More today, yes.
Q. I think we mentioned this earlier, but we talked about Admiral Levine.
Who is Admiral Levine?
A. Admiral Levine is the Deputy Surgeon General of the United States. 02:39:27
Q. Is Admiral Levine transgender?
MR. SELDIN: Object to form.
THE WITNESS: Yes.
MR. HILDABRAND: I will introduce what I want to mark as Exhibit 16. 02:39:45
(Reporter marked Exhibit Number 16 for identification.)
MR. SELDIN: And then before you get started, Counsel, I just -- I'm noting that the cover page of Exhibit 16 indicates that it's been redacted. Are those the redactions as filed, or has counsel -- 02:40:13
MR. HILDABRAND: Exactly. These are -- these are the redactions as filed on October 9th, 2024. 02:40:24
MR. SELDIN: Thank you for that.
Q. BY MR. HILDABRAND: Does this appear to be defendant's summary judgment Exhibit 186 in the Boe case from Alabama? 02:40:38

A. Yes.
Q. Have you seen this document before?
A. I think in a prior deposition.
Q. Are you aware that WPATH sent the version of the Standards of Care 8 that was approved by the chairs to Admiral Levine in 2022? 02:40:55
MR. SELDIN: Object to form.
THE WITNESS: Only from people asking about it in depositions. So I was not on -- on this email chain or -- you know, other than voting on Delphi, I was not, you know, an author of the adolescent chapter. 02:41:13
So yeah, I was not involved in -- in this email chain.
Q. BY MR. HILDABRAND: Okay. Let's go to -- it's page 11 in the document collection. It's BOEAL_WPATH_072114. 02:41:39
Have you seen this document before?
A. If I have, it was in a prior deposition.
Q. Do you see -- is this -- it appears to be an email to the adolescent Standards of Care 8 group? 02:42:04
A. Yes.
Q. Do you see where it says -- the paragraph, "We sent the document to Admiral Levine, Minister 02:42:14

of Health for the U.S.A., for their reviews"?
A. Yes. It sounds like whoever was authoring this was not American, since they thought she was the Minister of Health for the U.S.A., but yes.
Q. And so earlier on it says the whole document, over 500 pages, has now been checked for references, et cetera, and sent to the IJTH; is that right? 02:42:34
A. Yes. For publication.
Q. And this email was sent on July 29th, 2022? 02:42:45
A. Yes.
Q. Are you aware that Admiral Levine asked WPATH to remove the age limits for gender-affirming care? 02:43:06
MR. SELDIN: Object to form. Foundation.
THE WITNESS: Only, I think, from anything I may have read in the news or in depositions.
Q. BY MR. HILDABRAND: Do you see here in the email where it says, "Apparently, the situation in the U.S.A. is terrible, and she and the Biden administration worried that having ages in the document will make matters worse. She asked us to remove them." 02:43:16
A. Yes, I see that. 02:43:29

Q. Have you read that paragraph before?
A. Perhaps in a deposition, but I don't recall.
MR. HILDABRAND: And let's introduce one more document here. This will be Exhibit 17. And again, this was the version that was filed on the docket recently. I may make additional redactions. 02:43:53
(Reporter marked Exhibit Number 17 for identification.)
Q. BY MR. HILDABRAND: Does this appear to be defendants' summary judgment Exhibit 188 in Boe v. Alabama -- sorry, Boe v. Marshal? 02:44:29
A. Yes.
Q. Have you seen this document before?
A. I would have -- I don't know. Yeah. 02:44:44
Q. Let's go just to the first page here.
A. Sure.
Q. This is a page marked BOEAL_WPATH_106118. Have you seen this page before?
A. I -- only -- if I did, it was only in a deposition. 02:45:09
Q. Not for preparing a declaration or anything like that, right?
A. Not preparing a declaration.
Q. Is this -- 02:45:20

A. As far as I can recall, although I did in -- have a rebuttal declaration where I read a whole bunch of emails. But I don't remember what was in there, yeah, which ones.
Q. Does this appear to be a -- an email from Jon Arcelus? 02:45:33
A. Yes.
Q. Who is that?
A. Jon Arcelus was a -- one of the cochairs of Standards of Care 8. 02:45:45
Q. And it was to Walter Bouman; is that right?
A. Yes.
Q. Who's -- who's that?
A. Walter Bouman at the time, I believe, was chair of -- or board president of WPATH. 02:45:54
Q. And looks like Eli Coleman was cc'd.
Was Eli Coleman the overall chair of the WPATH Standards of Care Version 8?
A. Yes. 02:46:18
Q. Are you aware that WPATH agreed to remove the minimal ages in September 2022 to convince the AAP not to oppose the WPATH Standards of Care Version 8?
MR. SELDIN: Object to form. 02:46:34

THE WITNESS: So I'm -- I don't want to come to conclusions about full motivation. But I -- I do see that -- you know, from this email, that -- that they have expressed strong opposition, and that the -- that these meetings of folks 02:47:03 involved in Standards of Care 8, that they agreed to remove the minimal ages.
Q. BY MR. HILDABRAND: Do you see where it says, "In the last few days and as an emergency, we have had several meetings among the SOC8 chairs and 02:47:19 the adolescent chapter members"?
A. Yes.
Q. Were you involved in any of those meetings?
A. No. That -- I think those -- when they 02:47:27 say "SOC8 chairs," they meant the -- Eli Coleman and the two cochairs and then the adolescent chapter members.
Q. So you think they mean Eli Coleman, Asa Radix, Jon Arcelus? 02:47:45
A. Yes.
Q. And those are the three individuals who cosigned this email here?
A. Yes.
Q. And the email goes on to say that "We have 02:47:50

agreed to remove the minimal ages from the document. We have add a short sentence as agreed with AAP. We are hoping that by doing this, the AAP will be more satisfied, and they will not oppose the SOC8. We are waiting for their answer." 02:48:05
A. Yes.
Q. Were you aware -- have you ever seen this statement at the time that you prepared your declaration in this case?
MR. SELDIN: Object to form. 02:48:19
THE WITNESS: No. Unless, you know, the -- as I said, unless in the emails that I was supposed to review as an expert in one of the cases, unless this was one of those emails, but I don't recall reading this email before. 02:48:36
Q. BY MR. HILDABRAND: Are you aware that the Standards of Care Version 8 was not released on September 6, 2022, as agreed with its publisher because the American Academy of Pediatrics said they'd actively oppose SOC8 if the age limit stayed 02:48:57 in SOC8?
MR. SELDIN: Objection to form. Foundation.
THE WITNESS: No.
Q. BY MR. HILDABRAND: Let's turn to -- I 02:49:07

think it's page 38 in this collection. At the bottom it says BOEAL_WPATH_106656.
Have you ever seen this email chain before?
A. No, not as far as I can recall. 02:49:38
Q. Do you see the "To" line says, "WPATH BOD"? Is that the WPATH board of directors?
A. Yes.
Q. Were you on the WPATH board of directors at the time, or did you join later? 02:49:50
A. No. I was on the WPATH board of directors from 2014 to 2018.
Q. Great. Thank you.
In the grade methodology, if I said that there were five paradigmatic contexts where a 02:50:13 strong --
(Clarification by the reporter.)
Q. BY MR. HILDABRAND: Paradigmatic contexts, where a strong recommendation can be made based on low-quality evidence, would you be familiar with 02:50:23 what I'm referring to?
MR. SELDIN: Object to form.
THE WITNESS: I would have to look at the -- at the document.
Q. BY MR. HILDABRAND: Okay. So you couldn't 02:50:32

right now name for me any of those five paradigmatic contexts where a strong recommendation could be made based on low-quality evidence?
MR. SELDIN: Object to form.
THE WITNESS: No. I mean, strong recommendations are made, and certainly national -- you know, most national practice recommendations are made on low or very low-quality grade or no grade evidence. But I don't know the quote that you're seeking. 02:50:47 02:51:09
Q. BY MR. HILDABRAND: Does the grade system provide recommendations for care?
MR. SELDIN: Object to form.
THE WITNESS: So the -- the grade system provides a level of certainty of using a particular set of data in order to believe that something is true. 02:51:25
Q. BY MR. HILDABRAND: All right. So does it provide recommendations for care, or is that distinct from what the grade system does? 02:51:47
MR. SELDIN: Object to form.
THE WITNESS: So that's distinct from the grade recommendations, because people -- because you can have a low grade. The grade could be of low certainty. And yet the -- you know, 02:52:06

recommendations are made for -- for care. And indeed most recommendations for care are made with low certainty or a very low certainty or no grade at all.
Q. BY MR. HILDABRAND: I know today we focused on the WPATH standards of care quite a bit. 02:52:24
But did the 2017 Endocrine Society guidelines for -- the individuals who drafted the 2017 Endocrine Society guidelines, were those individuals all endocrinologists? 02:52:43
MR. SELDIN: Object to form.
THE WITNESS: I would have to look at the -- at the list of members.
Q. BY MR. HILDABRAND: Yeah. I think we had that as Exhibit 4, to go back quite a ways here, but Exhibit 4. 02:52:56
MR. SELDIN: Are you talking about the Endocrine Society guideline?
MR. HILDABRAND: Yes. The 2017.
Q. Can you identify any of the authors who is a surgeon? 02:53:05
A. Yeah. So -- I would say not all are endocrinologists, because Peggy Cohen-Kettenis is not an endocrinologist.
Q. What is Peggy Cohen-Kettenis? 02:53:18

A. She is a psychologist. She was at the time the head of the Dutch research team.
Q. Are any of the individuals who authored or coauthored the 2017 Endocrine Society guidelines surgeons? 02:53:33
MR. SELDIN: Object to form.
THE WITNESS: Not as far as I know. I -- I know the disciplines of most of these people, but I believe that are others are -- involved are endocrinologists. 02:53:57
Q. BY MR. HILDABRAND: Were several of the individuals who are authors, they are also coauthors of the WPATH Standards of Care Version 8?
MR. SELDIN: Object to the form.
THE WITNESS: Yes. I assume that Stephen Rosenthal, Joshua Safer, Vin Tangpricha, maybe -- maybe Gaya, that some of those people were also on Standards of Care 8. 02:54:08
Some of them were -- were probably retired or too old to be on Standards of Care 8. 02:54:28
Q. BY MR. HILDABRAND: And do the 2017 Endocrine Society guidelines also include recommendations about gender-affirming surgeries?
MR. SELDIN: Object to form.
THE WITNESS: They -- they do make some 02:54:40

reference, from my recollection.
Q. BY MR. HILDABRAND: Do the 2017 Endocrine Society guidelines provide any recommended minimal ages for gender-affirming surgeries?
MR. SELDIN: Object to form. 02:54:56
THE WITNESS: I would have to look again. But I think they do somewhere here make some recommendations, but I would have to look specifically for where they -- where they say that.
Q. BY MR. HILDABRAND: So off the top of your head, you don't know if the 2017 Endocrine Society guidelines make recommendations about gender-affirming surgeries? 02:55:16
A. I think that they -- my recollection is that they may have in terms of chest surgery and, you know, that the people are adults and getting general surgery. But I don't -- I don't recall. Certainly the focus of the guidelines were endocrine treatments, not surgical treatments. 02:55:33
Q. Do you want to -- if you would move to page 3893 in this document. 02:56:18
A. Yeah.
Q. Do you see where the 2017 Endocrine Society guidelines provide criteria for gender-affirming surgery which affects fertility? 02:56:30

A. Yes.
Q. So the 2017 Endocrine Society Guidelines provided criteria for gender-affirming surgery?
A. Yes. And in particular here, yes, effects -- yes. 02:56:48
MR. HILDABRAND: If we want to take -- let's go off the record now, if that's all right.
THE VIDEOGRAPHER: We're off the record. The time is 2:56 p.m.
(A recess was taken.) 03:06:25
THE VIDEOGRAPHER: Okay. We're back on the record. The time is 3:05 p.m.
Q. BY MR. HILDABRAND: Dr. Karasic, let's go back to what was marked as Exhibit 15.
A. Which one? Okay. 03:06:37
Q. We're going to go to page 42. Also marked at the bottom is BOEAL_WPATH_109285.
A. Page 42?
Q. Yes. Have you seen this email at the top before? 03:07:06
A. Yes.
Q. And this is an email you sent to Eli Coleman on August 28, 2021; is that correct?
A. Yes.
Q. And did you tell Eli Coleman, "I will come 03:07:22

up with an edited updated draft of the medical necessity statement for the introduction"?
A. Yes.
Q. And let's go to page 64. That's also marked at the bottom as BOEAL_WPATH_126702. 03:07:48
A. Yes.
Q. All right. And this -- is this an email you sent in May 2022?
A. Yes.
Q. And did you suggest, "Is the Delphi 03:08:04 statement on medical necessity in the medical necessity statement we have been circulating still going in the introduction of SOC8? If so, then a different refocused statement could go in a global chapter"? 03:08:22
A. Yes. This was in response to an email chain, again, where probably the same person was objecting to having this U.S.-centric statement, I assume. And so there was a discussion of different possibilities of -- and -- and I think that's what 03:08:43 I meant.
Q. Okay. Have you answered all the questions today fully and truthfully to the best of your ability?
A. Yes. 03:08:57

MR. HILDABRAND: I will turn it over to plaintiffs, reserve, of course, any redirect.
MR. SELDIN: Thank you. We don't have any questions for the witness. We will, however, read and sign. Thank you. 03:09:08
Also, I have noted that within this deposition, there was certain discussions of a specific patient of Dr. Karasic's. We've marked that confidential.
I know there's a pending email about how 03:09:21 we're dealing with confidential information in other contexts. You and I will sort that out. But I just want to note, again, that we do have a confidential portion of this deposition transcript as it stands. 03:09:28
MR. HILDABRAND: Thank you.
We reserve, of course, our rights on it being designated or not, but we'll sort that out later.
And we, of course, would like to have the 03:09:34 transcript ordered, I think expedited.
MR. SELDIN: And plaintiffs will have what defendants are having in terms of time. So thank you.
MR. HILDABRAND: All right. 03:09:43

THE VIDEOGRAPHER: This concludes today's deposition of Dr. Dan Karasic. The master media of today's deposition will remain in the custody of Magna Legal Services. The time is 3:09 p.m.
(Whereupon the proceedings were concluded at 3:09 p.m.)
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I have read the foregoing deposition transcript and by signing hereafter, approve same.
Dated_____.

_____
(Signature of Deponent)

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(Civ. Proc. § 2025.520(e))
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) Ss
COUNTY OF SAN FRANCISCO)

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I am the deposition officer that stenographically recorded the testimony in the foregoing deposition and the foregoing transcript

is a true record of the testimony given. (Civ. Proc. § 2025.540(a))

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Dated: _____

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(Civ.Proc. § 2025.520(e))

STATE OF CALIFORNIA)
) Ss.
COUNTY OF SAN FRANCISCO)

I, Balinda Dunlap, hereby certify:

I am the deposition officer that stenographically recorded the testimony in the foregoing deposition.

Written notice pursuant to Code of Civil Procedure, Section 2025.520(a), having been sent, the deponent took the following action within the allotted period with respect to the transcript of the deposition:

( ) In person, at the office of the deposition officer, made the changes set forth on the original of the transcript. (The parties attending the deposition have been notified of said changes.)

( ) Approved the transcript by signing it.

( ) Refused to approve the transcript by not signing it.

( ) By means of a signed letter, made the changes and approved or refused to approve the

transcript as set forth therein. (Said letter has been attached to the original transcript and copies thereof mailed to all parties attending the deposition.)

( ) Failed to approve the transcript within the allotted time period.

Dated _____.

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